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ABSTRACT

The information in this manual will help community planners, policymakers, and service providers develop and implement programs to better prevent HIV and other blood-borne infections. Findings from more than 30 studies report that community-based outreach is an effective strategy for reaching the drug-using population and for providing them with the means of a behavior change. The model represents community-based outreach as a primary vehicle for accessing out-of-treatment drug users at risk and eliciting their commitments to HIV/AIDS risk reduction, followed by two sessions of risk-reduction counseling and education. Since the model was designed and tested nationally, it can adapt readily to the specific characteristics and needs of any community. Section 1 presents background information on the development of the model. Section 2 outlines the step-by-step procedures for community outreach and personal risk assessment and reduction. Section 3 discusses implementation issues, including training and supervision. (Contains 4 appendixes and 20 references.) (JDM)

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The NIDA Community-Based Outreach Model:

A Manual To Reduce the Risk of HIV and Other Blood-Borne Infections in Drug Users

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Acknowledgments

Many people have made important contributions to the development of the National Institute on Drug Abuse's (NIDA's) HIV/AIDS Prevention Research Program. This manual would not have been produced without the input of National AIDS Demonstration Research (NADR) program and NIDA Cooperative Agreement (CA) program investigators and their staffs, who have contributed significantly to the science and practice of HIV/AIDS prevention. Principal investigators of the NADR and CA programs are listed in Appendices C and D.

The NIDA Community-Based Outreach Model is based on more than 15 years of NIDA-funded research. The Model incorporates the best features of three previously developed field manuals on community-based outreach HIV prevention interventions: the NIDA HIV Counseling and Education Intervention Model (Coyle, 1993); the Behavioral Counseling Model for Injection Drug Users (Rhodes, 1993); and the Indigenous Leader Outreach Model (Wiebel, 1993).

Special acknowledgment is extended to Michelle Wood, of the Center for Behavioral Research and Services at California State University, Long Beach, for her in-depth contributions in writing and preparing this manual.

This manual was developed under the leadership of Richard H. Needle, Ph.D., Chief of NIDA's Community Research Branch from 1992-1999. Helen Cesari, M.Sc., Elizabeth Lambert, M.Sc., Dionne Jones, Ph.D., and Susan Coyle, Ph.D., provided critical guidance in writing and editing the manual.

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The cover photograph is of a painting by Community Health Outreach Worker Craig Lasha. Entitled "Reaching Out: Preventing HIV/AIDS in Our Community," the painting depicts outreach workers talking to people on the streets of San Francisco's Tenderloin District. It was painted in 1989.

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Preface

The National Institute on Drug Abuse (NIDA) is pleased to provide this manual on a scientifically tested model of community-based outreach to reduce the risk of HIV and other blood-borne infections in drug users.

Since 1985, NIDA has conducted research to determine the most effective ways to reduce the risk of HIV/AIDS transmission in drug users and their sexual partners. Findings from more than 30 studies report that community-based outreach is an effective strategy for reaching drug-using populations and providing them with the means for behavior change.[1] Of those drug users who participated in community-based outreach interventions, a significant number entered treatment for their drug addiction—a primary goal of any HIV prevention effort with drug users. Many others participating in these outreach interventions stopped or at least reduced their frequency of drug injection and their reuse of injection equipment.

The NIDA Community-Based Outreach Model described in this manual is based on more than 15 years of NIDA-funded research.[2] The Model has been implemented and tested in 52 communities with more than 60,000 injection drug users and with many of their sex partners. The Model has also been adapted and tested with nearly 14,000 crack users and tailored to the needs of specific at-risk subgroups, including women who inject drugs, men who use drugs and have sex with men, and drug and sexual risk networks. Overall, the Model has been found to be effective with multiracial, multiethnic, male and female, HIV seropositive and seronegative, infected and non-infected drug-using populations residing in areas with low, medium, and high HIV prevalence.

This manual contains information that will help community planners, policymakers, programmers, and service providers develop and implement programs to better prevent the spread of HIV and other blood-borne infections. Specifically, the manual provides:

- Research-based principles of HIV prevention for drug-using populations not in drug treatment;
- Background information on community-based HIV prevention, including how it works, why it works, where it works, and for whom it works;
- A discussion of the roles and personal characteristics of effective community-based outreach workers;

- Step-by-step instructions for conducting community-based outreach and risk-reduction counseling sessions for out-of-treatment drug users and their sex partners;
- Information for program managers on how to establish a community-based outreach HIV/AIDS risk-reduction prevention program locally, establish a field station, and provide training and supervision to staff.
- Cue cards to be used or adapted during educational and risk-reduction counseling sessions.

I hope you find this research-based manual helpful in your HIV prevention efforts with drug-using populations. Free copies may be ordered from the National Clearinghouse for Alcohol and Drug Information (1-800-729-6686). In addition, the manual is available for viewing and downloading from the NIDA Web site at www.drugabuse.gov.

Alan I. Leshner, Ph.D.
Director

Contents

Acknowledgments ii

Preface iii

Section I: Background Information 1

Chapter 1, Background 3

Introduction 3

Research-Based Principles of HIV Prevention for Drug-Using Populations 3

Research Support 7

Intervention Philosophy 8

Chapter 2, Overview 11

Overview of NIDA's Community-Based Outreach Model 11

Compatibility With Other Programs 12

Chapter 3, Logistics of the Model 13

Community Factors 13

Target Populations 13

Appropriate Settings for Program Activities 14

Intervention Format and Other Features 14

Section II: Step-by-Step Procedures 17

Chapter 4, Community-Based Outreach: Accessing and Engaging Those At Risk 19

Community-Based Outreach Workers 19

Identifying Potential Outreach Sites 21

The Outreach Contact 22

The Dynamic Outreach Process 25

Chapter 5, Session I: Personal Risk Assessment and Strategies for Risk Reduction 27

General Information About Sessions I and II 27

Topics Covered in Session I 27

Getting Started 28

Basic Information About HIV, HBV, and HCV 29

Injection-Related Risks and Prevention Strategies 30

Sex-Related Risks and Prevention Strategies 32

Benefits of Drug Treatment and Cessation of Drug Use 34

HIV, HBV, and HCV Antibody Testing 35

Materials To Support Risk Reduction 35

Voluntary HIV, HBV, and HCV Testing 36

Chapter 6, Session II: Reinforcement and Support of Risk-Reduction Efforts 37

Topics Covered in Session II 37

Getting Started 38

HIV, HBV, and HCV Seronegative (and Unaware) Participants 38

HIV, HBV, or HCV Seropositive Participants 40

Section III: Implementation Issues 45

Introduction to Implementation Issues 45

Chapter 7, Logistical Concerns 47

Establishing a Field Station 47

Hours of Operation 47

Working in Teams 48

Maintaining Contact With Participants 48

Recordkeeping and Accountability 49

Chapter 8, Training and Supervision 51

Basic HIV/AIDS Education 51

Job-Specific Training 52

Counselor and Educator Training 54

Ongoing Training 54

Supervision (Monitoring and Feedback) 54

Creating a Supportive Environment 55

Endnotes 57

References 59

Appendix A: Cue Cards for Session I 61

Appendix B: Cue Cards for Session II 81

Appendix C: Members of the National AIDS Research Consortium 89

Appendix D: Members of the Cooperative Agreement for HIV/AIDS Community-Based Outreach Intervention Research Program 95

SECTION I:

Background Information

- Chapter 1
- Chapter 2
- Chapter 3

CHAPTER

Background

Introduction

This manual is intended to serve as a guide for community-based HIV risk-reduction efforts targeting out-of-treatment drug users. The NIDA Community-Based Outreach Model described here represents the synthesis of findings and "best practices" from two national multisite intervention programs supported by the National Institute on Drug Abuse (NIDA)—the National AIDS Demonstration Research (NADR) program and the Cooperative Agreement (CA) for HIV/AIDS Community-Based Outreach/Intervention Research Program—as well as from several smaller evaluations of outreach-based prevention strategies. This Model features community-based outreach as a primary vehicle for accessing out-of-treatment drug users at risk and eliciting their commitment to HIV/AIDS risk reduction, followed by two sessions of risk-reduction counseling and education. The sessions are organized to include optional testing and pre- and post-test counseling for HIV and other blood-borne infections. Intervention activities draw on principles of HIV prevention for drug-using populations, communications theory about credible messengers, and health behavior theory about perceptions of personal vulnerability.[3,4]

This community-based outreach model can be viewed as a component within a larger program providing services to out-of-treatment drug users, or the model can be implemented independent of other program activities. Because the NIDA Community-Based Outreach Model was developed and tested nationally, it has been designed to adapt readily to the specific characteristics and needs of any community in which it is delivered.

Research-Based Principles of HIV Prevention for Drug-Using Populations

Research on HIV prevention in drug users has evolved in response to the dynamic nature of the co-occurring epidemics of drug use, HIV, and other blood-borne diseases. Over time, as the accrual of empirical findings on HIV prevention in drug users has increased, new opportunities have arisen to refine, replicate, and test key principles of effective behavioral interventions in a variety of risk populations and communities. In many instances, it has been necessary to adapt or tailor behavioral interventions to the needs of the target group or population. These adaptations have allowed for testing and refinement of a set of research-based principles of HIV prevention in drug-using populations. The principles, listed below, have withstood the test of time, and researchers have demonstrated time and again that consideration of these principles during development and implementation of behavioral intervention programs for drug users will increase the likelihood of desired outcomes.

- **It is important for a community to start HIV prevention programming as early as possible.** Moreover, even when HIV is well established, HIV prevention programming can have significant impact on the further spread of HIV/AIDS. Early prevention efforts have been successful in maintaining low levels of seroprevalence in many local settings. In geographic areas where HIV is well established, effective strategies can be introduced to prevent the spread of HIV to currently uninfected drug users, their sexual partners, and emerging populations at risk for infection.
- **HIV risk reduction in drug-using populations is an achievable goal.** The first objective of any contact with drug users is to get them to stop using drugs. Recovery from drug addiction can be a long-term process, however, and relapse into drug use may occur even among persons in drug treatment. To prevent the spread of HIV, drug users must reduce or eliminate those behaviors that place them and others at risk. Research has shown that appropriately designed prevention programs can reduce not only HIV transmission, but also that of other infectious diseases, such as hepatitis B and C and various sexually transmitted diseases.
- **Effective prevention programming requires a comprehensive range of coordinated services.** Drug users and their sex partners at risk for HIV are diverse, and no single prevention strategy will work for everyone. Moreover, specific individuals often require multiple interventions and an array of prevention services, either concurrently or at different points in their lives. Comprehensive strategies are most effective for individuals and communities, and they should include such services as community outreach, HIV testing and counseling, prevention case management, drug abuse treatment, sterile syringe access, and service delivery through community health and social service providers. Careful attention must be given to the coordination of services within a community.
- **Prevention programs must be based on a thorough, continuing assessment of local community needs; the effectiveness and impact of such programs must also be continuously assessed.** There is variation across the United States and worldwide in the nature and extent of drug abuse and the profile of the AIDS epidemic. Prevention strategies must be adapted to local community needs and resources. Ongoing surveillance of local drug use and HIV risk behavior patterns is important for refining program approaches over time and for evaluating program outcomes.
- **Prevention services are most effective in reaching at-risk populations when they are available in a variety of locations.** Drug users are dispersed throughout communities and have varying lifestyles. Thus, reaching at-risk populations requires providing HIV prevention services in a wide range of settings, including community health and social service agencies, hospitals and clinics, and drug treatment and correctional facilities. Coordination across settings enhances intervention impact and reduces unnecessary service duplication.

- **Already infected drug users and their sex partners are important target groups for prevention and treatment efforts.** Infected persons need special efforts to help them gain access and maintain adherence to treatments that can prevent progression of HIV disease. Research also has demonstrated that infected drug users are able to make major behavior changes to protect their injecting and sex partners.
- **Prevention efforts must target not only individuals, but also couples, risk networks, and the broader community of drug users and their sex partners.** Risk behaviors typically occur within small or large groups, and community-based outreach interventions that engage small and larger groups can be effective. Behavioral norms within a local drug-using community that permit sharing of injection equipment also need to be modified. Relying on opinion leaders in groups can be an effective strategy to influence the drug-using behaviors of risk networks.
- **Community-based outreach is an essential HIV prevention component and must be directed to drug users in their natural environments.** Drug abuse is usually a covert activity, making drug users and their sex partners difficult to access through traditional health and social service agencies. Indigenous outreach workers who are familiar with the drug use subcultures and local neighborhoods in their communities have been shown to be particularly effective agents of behavior change. Peer outreach workers can act as referral sources to service agencies and drug treatment facilities, distribute HIV/AIDS information and risk-reduction technologies, and provide skills-building demonstrations, such as syringe cleaning or condom application. They serve as opinion leaders who educate and influence their peers to reduce risks for HIV and increase behavioral self-efficacy. The outreach worker should repeat messages of HIV prevention at every contact with a drug user to reinforce how important it is to stop using drugs and reduce HIV risks.
- **Prevention interventions must be personalized for each person at risk. Effective prevention requires more than simply passing out information and risk-reduction supplies.** Persons at risk must be engaged in a personalized assessment of their own risk behaviors, assisted in identifying barriers to and resources available to help them change their behavior, and helped to formulate specific and achievable strategies to protect themselves and others.
- **Drug users and their sex partners must be treated with dignity and respect and with sensitivity to cultural, racial/ethnic, and gender characteristics.** Successful engagement of at-risk populations in interventions requires that they recognize that concern for them is genuine and that they are seen as capable of undertaking behavioral change. Outreach approaches must be socially and culturally appropriate.

- **Sterile injection equipment must be readily available to IDUs to reduce their need to use injection equipment previously used by other injectors.** Individuals are at high risk for HIV and other infections if they share or re-use someone else's syringe and other injection equipment (including cookers, cottons, and rinse water). Research has shown that access to syringe exchange and pharmacy syringe distribution programs, as part of comprehensive HIV prevention programming, is effective in reducing syringe sharing and in preventing the spread of HIV.
- **Interventions targeting injection risk must address not only the sharing of syringes, but also of other injection equipment (including cookers, cotton, water, and drug solutions that have been prepared for injection).** Although sharing of other injection equipment is less risky for transmitting HIV than sharing syringes, it presents a potential additional route of infection for HIV and other diseases (e.g., hepatitis B and C) and must be addressed. Sharing drug solutions (drugs mixed with water in preparation for injection) is a significant, but frequently overlooked, HIV transmission risk. Targeted interventions can enable drug users to reduce the risks associated with sharing injection equipment and drug solutions.
- **Risk-reduction information is necessary, but alone not sufficient, to achieve and maintain behavior change.** In addition to offering accurate and up-to-date information on risky behaviors, effective programs focus on enhancing motivation to change behavior patterns, teach concrete strategies and behavioral skills for reducing risk, provide tools for risk reduction, and offer reinforcements for initial behavior change.
- **Prevention efforts must address sexual transmission risks as well as risks associated with drug injection**. Many non-injecting drug users and their partners are at risk for HIV infection and its transmission because of unsafe behaviors associated with their drug use, such as engaging in unprotected sex. For all sexually active individuals, drug and alcohol use may reduce inhibitions and increase the likelihood of unsafe sexual behaviors.
- **HIV intervention programs must be sustained over time.** Although brief interventions have been shown to significantly reduce HIV risk among substantial numbers of drug users, brief interventions are seldom sufficient. Sustained and repeated interventions are usually needed.
- **Community-based prevention is cost-effective.** Sustained, well-designed prevention programs are cost-effective and can lead to substantial reductions in health care and social service costs associated with the treatment and care of persons with HIV/AIDS and other infectious diseases.

Research Support

NIDA initiated the NADR program in the mid-1980s in response to the emerging HIV epidemic among injection drug users. After starting the NADR program, NIDA established the CA program, which built on the findings and experience gained through the NADR program, and, because of changes in the epidemic, expanded the target population to include non-injecting crack cocaine users. In making community-based outreach central to these interventions, the NADR and CA programs further refined a proven approach for accessing and engaging out-of-treatment drug users[5] and drew on effective elements of theoretical behavior change models. Drug use experts were initially pessimistic about the ability of drug users and their sex partners to modify behaviors that place them at risk for HIV/AIDS. However, NADR and CA program findings demonstrate that significant risk reduction can be achieved through the delivery of appropriately designed prevention programs.[1,6] A brief description of each program follows.

NADR Program

The NADR program was a large study carried out from 1987 to 1991 in 29 sites across the United States that investigated the efficacy of outreach-based interventions for reducing HIV risks among out-of-treatment injection drug users and the non-injecting female sex partners of male IDUs. NADR grantees deployed indigenous outreach workers to access members of the target population and initiate risk-reduction activities throughout participating sites, on the streets and in other settings where IDUs tended to congregate. Basic risk-reduction activities usually involved face-to-face communication; the provision of literature on HIV/AIDS transmission, prevention, and treatment; and the distribution of materials to facilitate risk reduction (i.e., male condoms to reduce sexual risk and bleach "kits" to decontaminate syringes and reduce risk associated with needle use). Outreach workers also referred drug users to services available in the local community, including drug treatment services as well as HIV/AIDS treatment. NADR community-based outreach was generally followed with additional, structured activities, such as confidential HIV testing and counseling and individual risk assessments.

CA Program

The CA program was implemented in 23 U.S. sites from 1990 to 1999 and was designed to further advance the knowledge base gained through the NADR program. Successful elements of the NADR program were incorporated in the CA program, and the study design was refined according to scientific findings and new insights that had resulted. Consequently, in the CA program, out-of-treatment IDUs and crack cocaine users were accessed through community-based outreach and were assigned to basic or "enhanced" intervention services, with basic services held consistent across sites. Outreach activities were similar to those in the NADR program, but were defined more uniformly. The basic intervention entailed community-based outreach as a prelude to two education and counseling sessions, organized

around optional HIV testing and counseling to help drug users learn about their serostatus and the behavior changes needed to reduce transmission risks. The basic intervention evaluated in the CA program forms the core of the NIDA Community-Based Outreach Model presented in this manual.

Effectiveness of the NADR, CA, and Other Outreach-Based Programs

Study findings indicate that the outreach-based interventions designed and tested in the NADR and CA programs were effective in reaching at-risk individuals and enabling them to reduce risk behaviors and, consequently, their risk of acquiring HIV/AIDS. Community-based outreach was found to be an effective approach for reaching out-of-treatment drug users, providing materials to support HIV risk reduction, facilitating drug treatment entry and retention, providing referrals for HIV testing and counseling, and promoting HIV risk reduction. The consistency of results is evidence that a strategy of community-based outreach, counseling, and education interventions promoted beneficial drug- and sex-risk behavior changes.

Intervention Philosophy

Role of Outreach

Outreach is viewed as an essential component of HIV prevention efforts targeting out-of-treatment drug users. Because drug use is a highly stigmatized illegal activity, drug users and their sexual partners may be difficult to access through traditional medical and social service agencies. Outreach conducted by individuals indigenous to the local community and familiar with drug use subcultures has been found to be highly effective in accessing out-of-treatment drug users and initiating behavior change.[1] Such individuals can serve as role models, educators, and advocates for individuals at risk, and because of their ongoing contact with members of the target population and local drug use settings, can monitor community trends and alert other program staff to changes in the drug use subculture that may influence the local epidemic. In addition, community outreach workers can advocate protective behaviors such as discontinuing drug use, using sterile syringes, disinfecting injection equipment, and using condoms among at-risk populations. The distribution of materials that facilitate risk reduction (condoms, lubricant, bleach, cottons, cookers, alcohol swabs, etc.) is an important function of community outreach workers in initiating behavior change. Likewise, providing information about the availability of sterile syringes, drug treatment, HIV/AIDS treatment, and other medical and social services within the local community is also important.

Role of Drug Treatment

In this Model, drug treatment is viewed as an important HIV prevention strategy, but it is not considered the only strategy. Although drug treatment is effective in helping many drug users overcome drug addiction and in reducing both needle- and sex-related HIV risks, not all drug users are ready to discontinue drug use. Furthermore, drug addiction is a chronic disorder, and relapse occurs frequently. Many individuals require multiple treatment episodes to achieve sustained abstinence. Therefore, other prevention strategies are needed for those who continue to use drugs and those who relapse. In the present Model, risk-reduction methods are presented in a hierarchy reflecting the relative efficacy of each approach. This hierarchy is displayed in Table 1. Cessation of all drug use and drug injection is presented as the most effective strategy for risk reduction. Those individuals who wish to discontinue drug use but do not feel able to do so on their own are encouraged to enter and complete drug abuse treatment, including relapse prevention. When individuals at risk feel unable or unwilling to abstain from drug use completely, a set of risk-reduction strategies to reduce personal and public health risks is promoted. Community-based outreach is an especially effective strategy for reaching out-of-treatment drug users who feel unable or unwilling to discontinue drug use and for helping them to understand their risks, change their risky behaviors, obtain HIV testing and pre- and post-test counseling, and enter and complete drug treatment.

TABLE Hierarchy of Risk-Reduction Strategies for Injection Drug Users

- Stop using and injecting drugs.
- Enter and complete drug abuse treatment, including relapse prevention.
- Take the following steps to reduce personal and public health risks, if drug injection continues:
  - Never reuse or "share" syringes, water, or drug preparation equipment;
  - Use only syringes obtained from a reliable source (e.g., pharmacies, syringe exchange programs);
  - Use a new, sterile syringe to prepare and inject drugs;
  - If possible, use sterile water to prepare drugs; otherwise use clean water from a reliable source (such as fresh tap water);
  - Use a new or disinfected container ("cooker") and new filter ("cotton") to prepare drugs;
  - Clean the injection site prior to injection with a new alcohol swab; and
  - Safely dispose of syringes after one use.

Source: CDC/HRSA/NIDA/SAMHSA. HIV Prevention Bulletin. Medical Advice for Persons Who Inject Illicit Drugs, May 1997.

HIV-Positive Drug Users

The present Model does not place particular emphasis on HIV-positive drug users. The reason is not because such individuals are viewed as unimportant targets for HIV prevention efforts, but rather because the intervention has an explicit focus on drug users who are unaware of their serostatus, featuring HIV counseling and testing as a core activity. Research has shown that infected drug users are able to make major behavior changes to protect their injecting and sexual partners. To this end, the present intervention Model can be adapted to help infected persons access and adhere to treatments that can prevent progression of HIV disease, inform their drug and sex partners about potential risk of infection and the importance of getting tested and counseled for HIV and other blood-borne infections, and initiate behavior change that may prevent transmission of the virus to others.

CHAPTER 2

Overview

Overview of NIDA's Community-Based Outreach Model

NIDA's Community-Based Outreach Model includes two interrelated components designed to facilitate behavior change among at-risk drug users. These include (1) community-based outreach and (2) two sessions of education and risk-reduction counseling that are organized around testing for HIV, hepatitis B virus (HBV), and hepatitis C virus (HCV), to provide pre- and post-test counseling to help drug users learn their serostatus and the behavior changes needed to reduce transmission risks.

In addition to accessing drug users in a variety of community settings, outreach workers serve as role models, educators, and advocates who can provide drug users with changing and accurate risk-reduction information in settings that are familiar to them and at times of greatest risk. Specific outreach strategies include communicating basic risk-reduction information; presenting a hierarchical framework for understanding the relative effectiveness of different risk-reduction strategies; providing literature and other materials to support behavior change; and facilitating access to drug treatment, HIV/AIDS testing and counseling services, and other medical and social services available in the local community.

Following the initial outreach contact, two sessions of individual HIV risk-reduction counseling are included as part of the Model; these can be held within the context of outreach contacts or can be conducted in an office setting, either by outreach workers or other staff (e.g., counselors, health educators). The first session provides basic information about the transmission and prevention of HIV, HBV, HCV, and other STDs, addressing sexual transmission risks as well as those associated with drug injection. The second session provides both a review of risk-reduction information and the opportunity to reinforce and support behavior change efforts. The sessions are designed to occur before and after HIV testing, which can be provided directly as part of the prevention program or, alternatively, can be offered indirectly by means of referral.

Compatibility With Other Programs

The NIDA Community-Based Outreach Model is readily adaptable to changing patterns of drug use and HIV risk behaviors in drug-using populations and local communities. Over time, the Model has evolved to incorporate new knowledge about drug use, risk behaviors, and the prevention of HIV and other blood-borne diseases and new techniques for HIV risk and serostatus assessment. However, effective HIV/AIDS prevention requires a range of coordinated services. The community-based outreach approach described here is designed to complement other prevention strategies that may already exist in a community, by offering referrals and opportunities to drug users to obtain HIV testing and counseling, HIV prevention case management, drug abuse treatment, and access to sterile syringes through pharmacies or syringe exchange programs. Because multiple providers will no doubt be involved in the delivery of services, careful attention must be given to the coordination of services within a community.

CHAPTER

Logistics of the Model

This Chapter describes the issues to be considered in customizing the NIDA Community-Based Outreach Model to a particular community. Community factors, such as the manner in which drugs are typically used, can bear on the particular subpopulations targeted, the risk-reduction messages presented, and the settings in which intervention activities occur. The format and other features of each intervention component are also presented.

Community Factors

In general, prevention programs are most effective when they are based on a careful and continuing assessment of local community needs. There is considerable variation within and across communities in the nature and extent of drug use, the course of the related HIV/AIDS, HBV, and HCV epidemics, patterns of risk-taking, and the availability of community resources. Thus, individual prevention programs likely will differ with community needs and resources. Even within communities, resource limitations may necessitate that prevention efforts be focused to reach those at greatest risk. Ongoing surveillance of local drug use and HIV risk behavior patterns provides important information for identifying new populations at risk and tailoring the content of prevention messages to meet the specific and current needs of drug users within the community. Educational messages and risk-reduction strategies that are promoted as part of this prevention Model should reflect the needs of the community in which the program is conducted.

Target Populations

The specific out-of-treatment populations to whom prevention efforts are directed will vary from site to site, on the basis of HIV/AIDS, HBV, and HCV seroprevalence and incidence rates, and according to local patterns of drug use and risk. Awareness of existing prevention programs and the populations they serve is also important in determining high-risk groups in a given community.

Appropriate Settings for Program Activities

The NIDA Community-Based Outreach Model is readily adaptable for use in a variety of community settings in light of patterns and contexts of risk-taking in the local drug use "scene," as well as the availability of program resources.

Community-Based Outreach

Because of their familiarity with the drug use subcultures and local neighborhoods in their communities, outreach workers can access out-of-treatment drug users in their natural environments, including the streets, storefronts, parks, shooting galleries, crack houses, soup kitchens, homeless shelters, abandoned buildings, and syringe exchange programs. Using a converted recreation vehicle or van as a mobile home-base for outreach activities when targeting such places can be an effective means of reaching at-risk populations. The types of sites likely to yield access to drug users at risk for HIV/AIDS and other blood-borne infections will vary with the particular neighborhood and the time of day or night.

Counseling and Education Sessions

Sessions I and II can be conducted in an office setting or, alternatively, in the field. There are advantages and disadvantages to both settings. Office settings tend to be more controlled and predictable in terms of noise level, privacy, distractions, and safety. The major drawback of conducting sessions in office-based settings is that greater levels of effort and resources may be needed to ensure that individuals at risk maintain adequate access to intervention services. While street and other community-based and natural settings are more convenient sites for program activities, because participants do not have to provide their own transportation or rely on staff members, program staff have much less control over the environment in such settings. In addition, it may be more difficult, and in some cases inappropriate, to conduct activities such as condom and bleach demonstrations in the field.

Intervention Format and Other Features

Table 2 displays the general features of the NIDA Community-Based Outreach Model, including format, activities, staffing, and setting for each component. Programs that implement this Model must decide whether HIV test counselors or health educators will conduct the counseling and risk-reduction education sessions (Sessions I and II), or

outreach workers will be trained to do so. Similarly, programs must decide whether the sessions will be conducted within the context of community-based outreach or in an office setting. Finally, it must be determined if HIV testing and pre- and post-test counseling will be provided on-site or offered by way of referral.

TABLE 2 Features of the NIDA Community-Based Outreach Model

Component	Format	Activities	Staff	Settings
Basic Outreach Contact	Community-based, face-to-face outreach contacts (5 to 20 min.)	1) Accessing members of target population 2) Basic risk reduction messages (risk hierarchy) 3) Distribution of materials to support risk reduction (e.g., bleach and condoms) 4) Referrals to HIV testing, drug treatment, and other services 5) Linkage to other program components.	Community outreach workers, indigenous leaders, peer opinion leaders, drug user networks	Street, parks, storefronts, shooting galleries, soup kitchens, homeless shelters, etc.
Session I	Individual session, ideally conducted closely following Basic Outreach Contact. (20 to 30 min.)	1) In-depth risk reduction messages for HIV, HBV, and HCV 2) Risk reduction skills modeling and rehearsal 3) HIV pretest counseling	Outreach workers, counselors, health educators	Office-based or, alternatively, street or other community settings
HIV Testing	Confidential or anonymous HIV antibody testing (10 to 20 min.)	4) HIV antibody testing (or referral for off-site testing)	HIV test counselors, health educators, etc.	On-site or off-site
Session II	Individual session, 2 to 3 weeks after HIV test (or Session I, if not tested) (25 to 30 min., depending on HIV test results)	1) Risk reduction review 2) Reinforcement of behavior change efforts 3) Drug treatment, HIV/AIDS treatment, and other referrals, as appropriate	Outreach workers, counselors, health educators	Office-based or, alternatively, street or other community settings

SECTION

II: Step-by-Step Procedures

- Chapter 4
- Chapter 5
- Chapter 6

CHAPTER

Community-Based Outreach: Accessing and Engaging Those At Risk

The process of community-based outreach involves identifying and making contact with members of the target group in their natural environments, establishing rapport, enlisting commitment to behavior change, and providing information about risk behaviors and strategies to eliminate or reduce risk. Guidelines for conducting outreach in general, and specific instructions for the present Model follow. Additional information about outreach worker training and supervision is contained in Chapter 8.

Community-Based Outreach Workers

Community-based outreach workers should reflect the ethnic, gender, and cultural diversity of the drug users targeted for the intervention and, when appropriate, should include individuals who are bilingual and bicultural. Tailoring community-based outreach to participants with language barriers is particularly important in reinforcing prevention messages and helping to prevent relapse into drug use and abandonment of risk-reduction efforts.

Advantages of Indigenous Outreach Staff

Community-based outreach to prevent HIV/AIDS among out-of-treatment drug users is typically conducted by individuals who are familiar with the drug use subculture and indigenous to the target community. In many cases, personal experience with drug use may be helpful, but this is not required. Outreach workers also may be affiliated with community-based organizations or local or State agencies and/or syringe exchange programs, enhancing their visibility and involvement in the broader community context. The advantages of employing outreach workers who are members of the local community are many; such individuals are often uniquely qualified to:

- Enhance program legitimacy;
- Translate technical information into readily understood concepts;
- Understand the norms and values of group members to help identify viable behavior change strategies;
- Recognize the contextual barriers (e.g., paraphernalia laws) that impede progress toward risk reduction;
- Establish trust with target group members;
- Improve follow-up capabilities for reinforcing behavior change;
- Facilitate access to high-risk sites;
- Foster wider community acceptance; and
- Know local community settings that can be effective sites for outreach activities.

Personal Drug Use Experience

Although not required, hiring community-based outreach workers who have personal drug use experience offers several advantages. For example, such individuals can speak with credibility about barriers to initiating and maintaining behavior change, as well as the potential for overcoming those barriers. Community-based outreach workers with personal drug use experience are uniquely able to "broker" prevention activities to at-risk individuals on the recipients' terms and, at the same time, assess the effect of their efforts from the perspective of current drug users. Such insight may be of extreme use to program planners and other program staff. In addition, by maintaining abstinence, such individuals can serve as peer role models for the target group, drawing on their own experiences to help current drug users modify their own behavior. Having established relationships within the local treatment system may enable outreach workers in drug recovery to facilitate the entry of others into treatment.

However, an individual need not have personal drug use experience to be successful in the role of community-based outreach worker. To be effective, community-based outreach workers must be able to relate to active drug users on their own terms, communicate genuine concern, and view themselves as advocates for those at risk.

Needed Skills

To be most effective, community-based outreach workers should be vested in the philosophy of unconditional caring and respect for the target population. The ability to establish trust and communicate effectively with active drug users is essential. Community-based outreach workers also should be equipped with the appropriate skills and information, including knowledge of local resources likely to be of interest to out-of-treatment drug users (e.g., drug treatment, services for HIV pre- and post-test counseling, syringe exchange programs, food programs, and shelters). Other important abilities include organizational skills, accurate recordkeeping, successful networking with groups of individuals at risk, and the ability to recognize and maintain appropriate personal boundaries. Finally, community-based outreach workers must be able to work in the natural environments of drug users and within drug treatment and other service settings, both formally and informally. As credible sources of information in the local neighborhood, outreach workers who know how to obtain and provide referrals to a comprehensive range of community services and facilities can help drug users who are unaware or fearful of such services to enter and access them.

Personal Characteristics

Personal characteristics can empower community-based outreach workers to identify and expand their skills, understand the emotional and attitudinal environment within which communication takes place, and recognize their own personality strengths. Table 3 presents desirable personal characteristics for community-based outreach workers.

TABLE 3 Desirable Personal Characteristics of Community-Based Outreach Workers

Empathy	Understanding what another person is experiencing and communicating that understanding.
Respect	Showing appreciation for the dignity and worth of others and accepting the fact that individuals have a right to make their own decisions and manage their own lives.
Genuineness	Being oneself without pretense, role-playing, or defensiveness.
Concreteness	Specific communications that relate to the what, why, when, where, and how of something. Concreteness keeps the participant from avoiding or escaping the issues at hand.
Self-Disclosure	Revealing one's personal feelings, attitudes, opinions, and experiences.
Immediacy	Dealing with the feelings between the participant and the community-based outreach worker in the present.
Charisma	The dynamic force and magnetic quality of community-based outreach workers who are in command of themselves and able to communicate their competence and trustworthiness.
Commitment	A personal acceptance of responsibility to one's community and to working to produce changes and improvements in the lives of community members.
Discipline	The ability to adhere to guidelines or a program.
Conviction	Knowing one's purpose and the correctness of one's efforts despite opposition or attempted manipulation.

Identifying Potential Outreach Sites

Choosing locations for conducting program activities is an important task requiring thorough knowledge of the community. Identifying sites where drugs are purchased and used, and when, and locating major prostitution strolls are the first steps. Before making initial contacts with drug users, community-based outreach workers should identify areas where, and at what times of day or night, target group members congregate, such as drug "copping" or purchasing areas, shooting galleries, crack houses, bars, liquor stores, public housing projects, soup kitchens, check-cashing centers, lounges, pool halls, storefronts, and public parks. Indigenous outreach workers may draw on their personal experiences in identifying areas in the community where drug-related activity is prevalent, and outreach workers in drug recovery are likely to know specific sites where drug use once occurred. In addition,

information from representatives of local agencies (e.g., police, health departments, and drug treatment agencies) regarding where and when at-risk individuals can be found may be of use in identifying appropriate outreach locations.

The following techniques may be useful to community-based outreach workers in determining current patterns of drug use within a community:

- Enlisting the help of old contacts in the community;
- Drawing on the knowledge of friends and families, when appropriate;
- Talking to drug users on the street; asking them where they go to meet friends and other users, or to simply "hang out";
- Asking shop owners, residents, and other key individuals;
- Visiting public housing projects; and
- Talking to service providers and drug treatment counselors.

Once an area has been determined an appropriate site for conducting outreach activities, it may be beneficial for outreach staff to canvass the area at different times of the day and night, introducing the program and outreach staff members and announcing upcoming outreach activities to local business owners and residents. This effort may help increase community support for outreach activities and may enhance program visibility. Personal identification with the local community on the part of outreach workers can help them establish credibility; and providing legitimate reasons for conducting outreach in a particular area may help outreach staff allay concerns about possible ulterior motives for targeting the community at risk. Furthermore, this stage of program implementation allows outreach workers to establish among community members their genuine concern for the well-being of the local community and their compassion for its members who may be affected by drug use or HIV/AIDS.

The Outreach Contact

Identifying and Accessing Members of the Population

Once appropriate sites have been identified, community outreach workers may begin the task of conducting regular, ongoing outreach in these areas. Outreach workers often work in pairs to maximize visibility, credibility, and safety. Typically, outreach workers approach individuals who appear to be members of targeted populations in street or other community settings. Personal drug use experience may be helpful, but it is not required for accurately identifying current drug users. Outreach workers may begin conversations with likely drug users by introducing themselves, the program with which they are affiliated, and their purpose. The goal of helping drug users in the local area stay safe from HIV/AIDS should

be articulated directly, as this assertion will allow individuals who do not use drugs or who are already HIV-positive to identify themselves. Such individuals may be enlisted to pass information on to any drug users they know, and outreach workers should provide referrals to HIV/AIDS treatment, as appropriate. In general, individuals who appear hostile or threatening should be avoided.

Community-based outreach workers typically make contact with one or two individuals at a time, but they may sometimes approach larger groups. Workers may focus outreach activities specifically on small groups or networks of drug users, enlisting network leaders to endorse and model HIV/AIDS risk-reduction strategies among their peers as a means of diffusing the information and risk-reduction techniques more rapidly.

Core Information Provided

A conversation between an outreach worker and an individual at risk may last only seconds or may continue for several minutes, depending on the individual's interest and surrounding activities. At a minimum, the NIDA Community-Based Outreach Model includes four core activities that community-based outreach workers seek to accomplish during the course of an initial contact:

1. Discussing risk behaviors
2. Explaining ways to reduce risk
3. Providing written information and materials
4. Offering referrals.

These activities usually can be conducted within a 5- to-20-minute conversation.

1. Risk Behaviors. Once rapport has been established, community-based outreach workers may initiate a discussion of both drug-related and sex-related risk behaviors. Reviewing behaviors that put people at risk for HIV/AIDS and discussing personal risks can help determine which risk-reduction strategies may be most appropriate for the particular individual. In addition, misconceptions about risk behaviors can be addressed.

2. Risk Reduction. The hierarchy of safer behaviors (Table 1) may be employed to provide a framework for understanding various HIV risk-reduction strategies for IDUs. The drug-related hierarchy shown in Table 1 advises persons who inject drugs to stop using and injecting drugs to reduce risks and prevent HIV. Because most drug

users have difficulty stopping drug use on their own, they are urged to enter and complete drug abuse treatment, including relapse prevention. If IDUs cannot or will not stop injecting drugs, they should take the following precautions:

- Do not reuse or share syringes, needles, and other injection paraphernalia;
- Use only syringes obtained from a reliable source (e.g., pharmacies and syringe exchange programs);
- Use a new, sterile syringe to prepare and inject drugs;
- If possible, use sterile water to prepare drugs and otherwise use clean water from a reliable source (such as tap water);
- Use only new or disinfected containers ("cookers") and new filters ("cottons") to prepare drugs;
- Clean the injection site with a new alcohol swab prior to injection; and
- Safely dispose of syringes after one use.

Community outreach workers can help IDUs adhere to these recommendations by providing information about the availability of sterile syringes and their appropriate access within the local community. If new, sterile syringes and other injection equipment are not available, then previously used equipment should be boiled or disinfected with bleach as indicated in *Card 7*.

Hierarchical messages can be used also to explain safer sex behaviors (see *Card 11*). Abstinence from sexual activity should be described as the safest way to reduce sexual risk. The next safest method for reducing sexual risk is avoiding penetrative sex. Finally, using condoms should be recommended for all sex involving penetration.

In the context of discussing risk-reduction strategies, it is important for community-based outreach workers to emphasize that, although it may not be feasible to follow these recommendations all of the time, to minimize HIV/AIDS risk, individuals should adhere to these recommendations as frequently and as completely as possible.

3. Literature and Other Materials To Support Risk Reduction. In addition to verbally discussing risk-reduction methods with individuals, it also is important for community-based outreach workers to provide literature and other materials to support risk reduction. Providing pertinent printed materials substantiates the verbal messages provided by the outreach worker, reiterates the message at a later time, and typically provides a greater level of detail, empowering individuals by communicating exactly how to adopt particular prevention techniques. Thus, printed materials can reinforce messages initiated in the context of an outreach contact. Printed materials may include instructions for cleaning needles, syringes, and drug equipment; instructions for using latex condoms; information about where and how to access local service providers (including drug treatment; HIV, HBV, and HCV

testing and pre-and post-test counseling services; sterile syringe access; and other health services) and other important health information. In addition, providing pictorial information may help communicate risk-reduction messages to those who are unable to read.

4. Referrals. After providing printed information, community-based outreach workers may offer printed referrals for drug treatment and relapse prevention; HIV, HBV, and HCV testing and pre-and post-test counseling services; sterile syringe access; and other medical, social, and economic services, as appropriate. The goal is to provide at-risk individuals with a specific agency and resource person for needed information and support. Additional information that may facilitate access to community resources includes hours of operation, eligibility requirements, cross streets, and a general endorsement of the agency and the services offered. The outreach worker's describing positive relationships with and personal approval of staff members of local service agencies may help individuals feel more at ease in seeking care.

Encouraging Participants To Attend Sessions I and II

Upon successful communication of core information, community-based outreach workers may encourage individuals to participate in the remaining elements of the present intervention Model: two counseling and education sessions conducted in connection with HIV testing and pre- and post-test counseling (described in Chapters 5 and 6), if these components are offered, as well as any other add-on services that are provided by the agency. Add-on services might include multiple counseling sessions, couples counseling, group counseling, role-playing exercises, behavioral contracting, community events, STD services, HIV treatment, and syringe exchange, for example. If HIV testing with counseling and education are not provided by the agency directly, community-based outreach workers may encourage individuals to access other local agencies that provide similar services.

It may be helpful for community-based outreach workers to explain available program services and to inform individuals of the following: (1) the usual amount of time spent in counseling and education sessions, (2) the location of program activities, and (3) the benefits of participation, including the availability of HIV, HBV, and HCV antibody testing, as appropriate. Community-based outreach workers also may encourage prospective participants to refer drug-using acquaintances to the program.

The Dynamic Outreach Process

Many factors contribute to the dynamic process that evolves during the course of an outreach encounter. The process is dependent on the particular individuals involved in the outreach contact, that is, the community-based outreach worker and the active drug user. The degree of rapport and openness that is established between these two individuals determines, to some degree, the particular content emphasized during a contact, as do the particular needs of the individual at risk. Rapport may depend on characteristics of the individual at risk, of the outreach worker, or a combination of the two, as well as on transient features of the immediate environment. The particular setting or context in which outreach is conducted

also influences this dynamic; individuals may be recruited at different times of the day or night, on the street, in storefronts, at shooting galleries, or through the use of outreach vehicles. They might be approached by community-based outreach workers, referred by other drug users, or self-referred to program services. Other outreach strategies, such as involving indigenous leaders versus peer opinion leaders versus networks, also contribute to the outreach dynamic.

It is the role of the community-based outreach worker to lead the interaction and direct the outreach process in light of each of these factors. Factors influencing the outreach dynamic may change at any time, and the outreach worker must be prepared and flexible. For example, an outreach contact with a sex worker may change quickly and dramatically if a prospective customer or police car appears on the scene. Likewise, the presence or absence of peers or sexual or drug-using partners may influence the interaction between outreach staff and individuals at risk. The time of day or night can have a major influence on the outreach interaction. For these reasons, community-based outreach must not be conceived as a fixed set of events or topics but, rather, a flexible exchange that depends on the confluence of a number of factors, each of which must be considered, and many of which may be beyond the outreach worker's immediate control.

Repeat Outreach Contacts

It is highly desirable for community-based outreach workers to engage at-risk drug users in multiple conversations. Repeat contacts may enable outreach workers to discuss prevention messages more thoroughly and to reinforce behavior change efforts. Furthermore, in some circumstances, it may not be possible for community-based outreach workers to convey all of the core information during one contact. Moreover, discussing HIV risk over the course of multiple conversations may enable greater disclosure on the part of drug users at risk, owing to their increasing trust of both the agency delivering outreach services and individual staff members.

Interaction Strategies and Tools

Community-based outreach workers have a variety of strategies and tools at their disposal for maximizing the impact of their interactions with individuals at risk. These include:

- Providing targeted information
- Weighing pros and cons
- Exploring barriers
- Exploring social support
- Giving praise
- Communicating confidence
- Role-playing
- Selective disclosing
- Giving real-life examples
- Posing open-ended questions
- Summarizing
- Listening
- Waiting
- Reflecting.

CHAPTER 5

Session I: Personal Risk Assessment and Strategies for Risk Reduction

General Information About Sessions I and II

Sessions I and II provide accurate and up-to-date information on risky behaviors, as well as concrete strategies and behavioral skills for reducing risk, and reinforcement for initial behavior change. A set of 24 cue cards (provided in Appendices A and B) is used to guide the sessions. The cards outline the full range of information to be discussed and activities to be completed during the session; however, particular cards may be emphasized or de-emphasized depending on the circumstances and the individual's risk profile. Although some of the topics may not apply to a given individual (e.g., needle disinfecting procedures can be skipped for those who do not use injection drugs), every effort should be made to cover all of the topics that are relevant. If this is not possible and a session must be cut short, the interventionist should reschedule the session to allow for the completion of remaining activities. This is less likely to be necessary when sessions are conducted in settings that are relatively more controlled, such as a store-front office. It is recommended that interventionists refer to the cue cards during sessions to guide their discussion with individuals at risk, and that each card be shown as it is discussed.

As mentioned in Chapter 3, Sessions I and II may be conducted either in an office or on the street, by outreach workers or other staff members. Because of their length (20 to 30 minutes), the personal nature of their content, and their format, Sessions I and II may be best suited to a controlled, office environment. However, it is possible to conduct sessions in the field, and there are some real benefits to doing so (see Chapter 3). Police activity, availability of resources, and weather conditions are only a few of the issues to consider in planning how best to implement this component of the NIDA Community-Based Outreach Model in a given community.

Topics Covered in Session I

Session I reinforces and builds on the basic HIV/AIDS education and risk-reduction messages conveyed during community-based outreach. Focusing on the risks of HIV/AIDS, HBV, HCV, and other STDs associated with drug use practices and sexual behavior, the session is intended to personalize risk-reduction messages and support behavior change

efforts. The session draws on social learning principles and features modeling and skills-building activities to facilitate risk reduction. Topics addressed in Session I are outlined in 18 cue cards *(Cards 1 through 18)* and include the following:

- Basic information about HIV, HBV, and HCV;
- Injection-related risks and prevention strategies;
- Sex-related risks and prevention strategies;
- Benefits of drug treatment and cessation of drug use;
- Information about HIV antibody testing;
- Distribution of literature and other materials to support risk reduction, including referrals; and
- Voluntary testing and pre- and post-test counseling for HIV, HBV, and HCV (on site or by referral).

Getting Started

If conducted in an office, the session should be held in a comfortable and private place. Likewise, if conducted in the field, community-based outreach workers should identify a comfortable location affording as much privacy as possible. Interventionists should always introduce themselves by name and explain their role as an outreach worker, educator, and/or interventionist. Before Session I commences, it is important to inform participants about the general topic areas to be covered and the expected duration of the session.

While some of the material may seem instructive in nature, pacing the session and allowing time for questions will make the session less didactic and more interactive. By asking and encouraging questions, listening for concerns, and offering support, the interventionist can personalize the session and obtain a more accurate and complete picture of the participant's risks.

The following materials are needed to conduct Session I:

- *Cards 1 through 18;*
- Cup with clean rinse water;
- Container with full-strength household bleach;
- Empty cup;

- Bottle cap (cooker model);
- Demonstration syringe (no needle);
- Dildo or other anatomical model;
- Condom;
- Lubricant;
- Pair of blunt scissors;
- Written referrals for HIV, HBV, HCV, and other STD testing, pre- and post-test counseling, and treatment; drug treatment and relapse prevention; sterile syringe access; and other social and medical services;
- One or more needle hygiene kits; and
- One or more condom kits.

Basic Information About HIV, HBV, and HCV

Card 1 provides basic information about AIDS and its viral source. National and local transmission and infection rates should be discussed, and the point that HIV/AIDS is a local community problem should be made. The interventionist can use examples like the body's reduced ability to fight off colds and common infections as well as more rare diseases to explain the destructive effect of HIV on the immune system.

Card 2 provides basic information about HBV and the negative health effects of hepatitis B. The interventionist should emphasize the elevated blood-borne transmission risk of IDUs and individuals with multiple sex partners. Information about the availability of HBV testing, vaccination, and treatment options in the local community also should be provided.

Card 3 provides basic information about HCV and the damage that hepatitis C can cause to the liver. Again, the special risks of IDUs and individuals with multiple sex partners should be emphasized, and local agencies providing testing, counseling, and treatment should be mentioned.

Card 4 describes behaviors that put people at risk. The interventionist may ask the participant to assess his or her own risk situation when discussing this card. It is important to emphasize the risks associated with sharing drug paraphernalia such as needles, syringes, and cookers, as well as cotton and rinse water. The risks associated with sharing drugs

administered through the same syringe via front- or backloading[7] should be discussed carefully. Also, the risks of engaging in unprotected sex, especially with persons who have a history of drug use or multiple sexual partners, should be emphasized. The disinhibiting effects of drugs and alcohol that may lead to risk behavior or weaken the immune system should be explained, and the common risk factors for HIV, HBV, HCV, and other STDs, as well as the effect of STDs on HIV, HBV, and HCV transmission, should be discussed.

Card 5 describes common misconceptions about HIV, HBV, and HCV transmission. These should be explained in detail if the participant seems to endorse the myths described or to have difficulty understanding risk concepts. It is important to allow sufficient time for questions.

Injection-Related Risks and Prevention Strategies

Card 6 provides information on the risks associated with sharing injection paraphernalia and the importance of disinfecting needles and syringes. When a participant believes that he or she cannot stop injecting drugs or sharing equipment, disinfecting injection paraphernalia should be promoted as a means of reducing, although not eliminating, the risk of HIV, HBV, and HCV transmission. Clearly, it is preferable for drug injectors always to use sterile supplies and never to share them. When this is not possible, cleaning and disinfecting techniques should be considered.

It is important for at-risk individuals to attempt to disinfect all injection paraphernalia that are known or suspected to have been used by someone else. It is also important for participants to be aware of risks from indirect sharing practices (e.g., using one syringe to measure or distribute the drug, extracting the drug from used cotton, etc.) and to avoid engaging in such practices. Full-strength bleach is the most effective disinfectant when IDUs have no safer alternatives. Boiling needles and syringes for 15 minutes between uses can sterilize the equipment. However, boiling may alter the shape and functioning of the plastic syringes widely used by injecting drug users in the United States. Sterile/unused needles and syringes are safer than previously used needles and syringes disinfected with bleach.[8] Using a disinfectant may not offer 100 percent protection, but it is likely to reduce the risk of spreading infection through contaminated supplies.

Card 7 provides information on proper techniques for cleaning injection equipment. The interventionist should note that cleaning and disinfecting are best accomplished immediately after injection equipment has been used. Once any residual blood in needles, syringes, or cookers has clotted, thorough cleaning and disinfection becomes more difficult. To be effective, all contaminated surfaces must be exposed twice to full-strength bleach for at least 30 seconds each time.

Whenever possible, the interventionist should demonstrate to drug injectors how to disinfect syringes and other injection equipment. (This may not be feasible when the session is conducted in street settings.) The following materials are required when demonstrating proper disinfection techniques:

- Cup with clean rinse water;
- Container with full-strength household bleach;
- Empty cup;
- Bottle cap (cooker); and
- Demonstration syringe (no needle).

To demonstrate proper needle disinfection, full-strength bleach should be drawn through the submerged tip of the syringe to fill the barrel, and the barrel should be shaken or tapped to agitate the contents for 30 seconds. The interventionist should stress that only full-strength household bleach and clean, unused water should be used for disinfection of needles and syringes. Next, the bleach should be discharged for disposal, or squirted into the cooker if the cooker is also being cleaned. If the back tip of the plunger is used to mix the drug solution, it can be cleaned by immersion in the bleach contained in the cooker. Once completed, this process should be repeated.

After the syringe is disinfected with bleach, clean water should be drawn through the submerged tip of the syringe to fill the barrel, and then the water should be discharged and disposed. When completed, this process also should be repeated. If the cooker is being cleaned, water can be used to flush out any residual bleach, and the back plunger tip can be rinsed off by being dipped into the water in the cooker. It is important for the interventionist to emphasize that water and bleach used to clean injection equipment should never be reused, and that they should be discarded into a sink, toilet, sewer, or discard bottle whenever possible. They are hazardous waste! The interventionist also should emphasize that all injection equipment should be cleaned after each use.

The interventionist may suggest that the participant take the syringe apart (remove the plunger) to improve the cleaning/disinfection of parts that might not be reached through flushing with water and bleach. Next, the participant should be asked to demonstrate his or her proficiency by cleaning the needle and syringe as directed. Playback may be continued until proficiency is achieved. (It is anticipated that at least 90 percent of participants will be proficient by the first rehearsal.)

Card 8 clarifies transmission risks associated with shared injection equipment. The interventionist should emphasize that all of these forms of sharing can result in the transmission of HIV, HBV, and HCV. Equipment used for the disinfection demonstration in *Card 7* may be used to help clarify any questions about indirect sharing risks, if appropriate.

Card 9 highlights potential benefits of needle exchange. Information about related services available in the local community should be provided.

Sex-Related Risks and Prevention Strategies

Card 10 points out sexual risks associated with cocaine and crack use. It is important to emphasize the link between the use of crack and other cocaine and the diminished ability to practice safer sex, and also how these drugs may compromise the immune system. If the participant uses crack or other cocaine, he or she should be encouraged to stop using the drug. If the participant does not believe that discontinuing drug use is possible, practicing safer sex and not initiating drug injection should be advocated. In addition, it should be noted that injection drug users who do not use crack or other cocaine may also be at sexual risk for HIV/AIDS, HBV, and HCV, as may amphetamine injectors and non-injectors, alike.

Card 11 presents information about male condoms. The benefits of condoms in preventing the spread of HIV/AIDS and other sexually transmitted diseases (which in turn can promote the transmission of HIV, HBV, and HCV) should be reviewed. The interventionist should explain that while the risk of transmission associated with unprotected oral sex is not as great as those associated with unprotected vaginal and anal sex, to be as safe as possible, a latex barrier is recommended. The hierarchy for understanding sexual risk (abstinence, having only non-penetrative sex, and consistent condom use for all penetrative sex) should be explained in terms of *relative* risk, and these should be presented as flexible risk-reduction alternatives. Reducing the number of sexual partners should also be discussed, if appropriate.

After reviewing the information in *Card 11*, the interventionist may demonstrate proper condom use. Materials needed for the demonstration include:

- Dildo or other anatomical model;
- Condom;
- Lubricant; and
- Pair of blunt scissors.

Points to emphasize include the importance of keeping condoms in a cool place and how to open the package correctly to avoid weakening or piercing the condom. Using the anatomical model, the interventionist may demonstrate the correct placement of the condom and the risk associated with flipping a condom over after it has been placed "wrong side up"; the importance of pinching the tip to allow adequate space for the ejaculate; and proper removal and disposal. The use of lubricant should be described, and the interventionist may encourage participants who have never used lubricant to feel its texture. The interventionist may explain that placing a small amount of lubricant on the inside tip of the condom before use may increase sensitivity and maximize sensation. The use of two condoms at once should be discouraged. The types of condoms that protect against HIV, HBV, and HCV transmission and the types of lubricants that can be used safely with condoms should be discussed, and the interventionist can show how a condom can be cut to create a barrier for oral-vaginal sex.

At this point, the participant may be asked to demonstrate his or her proficiency by fitting a condom on the model. Playback should be continued until proficiency is achieved. (Note: It is anticipated that 90 percent of participants will be proficient by the first rehearsal.)

Card 12 introduces the female condom and discusses its positive features. The interventionist may explain that the female condom has the following advantages over the male condom, both for contraception and STD prevention:

- The female condom is primarily woman-initiated: women are not as dependent on the cooperation of sex partners to protect themselves from HIV/AIDS and other sexually transmitted diseases as they would be if they were using male condoms.
- The female condom is inserted before intercourse, providing additional protection against infections from pre-ejaculate fluids.
- The female condom protects a greater proportion of the female genitals, thus providing further protection against STDs.
- The female condom has less risk of rupture than the male condom.

Other advantages of the female condom are that it causes less loss of sensitivity (because of its loose fit), it permits penetration before complete erection, and it permits continued intimacy following intercourse because it need not be removed immediately after ejaculation. Furthermore, the female condom has a lower leakage rate than the male condom, it is as effective as other barrier methods at preventing pregnancy, and in simulated laboratory testing, no HIV virus leaked out of the female condom. The participant should be warned

never to use female and male condoms at the same time, and that each female condom may be used only once. The availability of female condoms in the local community should be discussed, and questions should be answered.

Card 13 offers suggestions for talking about safer sex with partners. Since this kind of communication may be difficult for many participants, the interventionist may stress that having unprotected sex with a person infected with HIV/AIDS is one of the primary ways in which the disease is transmitted—therefore, the participant's life may depend on his or her ability to discuss practicing safer sex.

The interventionist should lead into a discussion of the cue card by explaining that talking to one's partner about practicing safer sex may not be easy, but it is an important first step in the process of protecting oneself from HIV, HBV, HCV, and other STDs. Just the thought of raising the issue with one's partner may cause discomfort, embarrassment, or worry about a partner's reaction. These are normal concerns that everyone shares. The participant should be informed that making a firm decision and commitment to himself or herself to have only protected sex will make it easier to talk to a partner about safer sex practices. This will also make it easier to stand firm if a partner tries to convince him or her to do otherwise.

After the points on the cue card have been discussed, the interventionist may reemphasize the importance of talking about safer sex. The participant can be reminded that HIV, HBV, HCV, and other STDs are facts of modern life: to not talk about them will not make these diseases go away. However, talking about them and practicing safer sex may save the participant's life.

Benefits of Drug Treatment and Cessation of Drug Use

Card 14 highlights the potential benefits of seeking and receiving drug treatment. The interventionist should encourage the participant to consider drug treatment as a way to stop using drugs and to reduce the risk of HIV/AIDS, HBV, HCV, other STDs, and other problems associated with drug use. The different types of treatment programs available locally and the different needs they serve should be discussed (e.g., methadone programs only treat opiate addicts, but some localities may also have therapeutic communities that treat other kinds of drug abuse). The participant should be reminded that even if immediate entry is not possible, he or she can be placed on a waiting list. In addition, any personal endorsement of local drug treatment programs and their staff may put participants at ease. The interventionist should indicate that later in the session, entry into treatment can be facilitated though referral, if desired.

HIV, HBV, and HCV Antibody Testing

Card 15 describes the blood test procedures for HIV antibody testing and the meaning of test results, including the uncertain nature of a negative result and the uncertain prognosis of a positive result. Additional information should be provided if an oral test, rather than a blood test, is offered. The advantages and disadvantages of testing, and when results will be available also should be discussed. Special attention should be paid to early medical treatment and confidentiality issues.

Card 16 describes the HBV testing procedure and the meaning of test results. If HBV screening is not provided on site, the local availability of screening and treatment should be mentioned.

Card 17 describes the HCV testing procedure and the meaning of the test results. Again, if HCV screening is not provided on site, the local availability of screening and treatment should be mentioned.

At this point, the interventionist may engage the participant in a discussion of the potential benefits and drawbacks of testing. Participants should be informed that public health officials recommend testing because the potential benefits far outweigh the potential drawbacks. It should be noted that the benefits include early treatment for HIV, HBV, and HCV infection and the ability to plan a health strategy that is best for the participant and his or her family and community. Despite these benefits, the interventionist must assure the participant that HIV, HBV, and HCV antibody testing is voluntary.

Card 18 outlines healthy behaviors that should be practiced when a person is infected with HIV, HBV, or HCV. Early medical intervention should be encouraged, and the dangers of taking in more virus through unsafe practices should be discussed. Practicing safer sex is important even when a person is already infected.

Materials To Support Risk Reduction

Before concluding the session, the interventionist should ask the participant if he or she has questions and should provide written materials containing information discussed in the cue cards, as well as other materials to support risk reduction. In addition to providing literature about HIV, HBV, and HCV transmission and risk reduction, literature on the female condom, which includes information on where it is available, may also be distributed. Referral lists for local drug treatment and relapse prevention programs and for HIV, HBV, and HCV testing and pre- and post-test counseling services should be offered (if available). Written referrals to other social and medical services also may be provided. In addition, one

or more needle hygiene kits and condom kits may be offered, as appropriate. Some participants may be reluctant to be seen carrying bleach and condoms in public; offering a small paper bag to hold these items may be helpful.

Individual programs may determine the quantity of items included in needle hygiene kits on the basis of available resources. If possible, additional materials beyond those listed below can be included. Needle hygiene kits should include the following:

- One or more alcohol swabs;
- One or more clean cotton balls or gauze pads;
- One or more bandages;
- One or more bottles of clean rinse water;
- One or more bottles of bleach;
- Written and pictorial descriptions of proper needle disinfection procedures; and
- Referral information for obtaining HIV testing and counseling, drug treatment, and other health services.

Likewise, quantities of items included in condom kits may vary, depending on resources. To increase interest in experimentation, a variety of condoms and lubricants may be included in each kit. Condom kits should include:

- One or more latex condoms (different brands, if possible);
- One or more packets of water-based personal lubricant (different brands, if possible);
- Written and pictorial descriptions of proper condom use procedures.

Voluntary HIV, HBV, and HCV Testing

Next, HIV, HBV, and HCV testing and pre- and post-test counseling should be provided if the individual agrees to be tested and if these tests are provided on site. Alternatively, the participant may be referred to a local clinic or service provider licensed by the State or county. If referred for testing, the participant should be notified that he or she may be required to sign an informed consent form. Finally, the interventionist should explain (1) any foreseeable discomfort, (2) the expected benefits of testing, (3) the extent to which records will be held confidential, and (4) the voluntary nature of the tests.

CHAPTER 6

Session II: Reinforcement and Support of Risk-Reduction Efforts

Session II provides HIV, HBV, and HCV post-test information for individuals who have participated in testing, and a risk-reduction booster session for all participants who return, regardless of whether they were tested. Generally, Session II should be held within 6 weeks after the scheduled HIV, HBV, or HCV test. (It is expected that 90 percent of those contacted will return for Session II within 3 weeks.) The session is expected to last between 25 and 35 minutes, depending on test results. However, some seropositive individuals may require up to 60 minutes.

Topics Covered in Session II

Different content is provided for individuals who test seronegative versus those who test sero-positive for HIV, HBV, or HCV. Individuals who decline testing and are unaware of their status receive the same content as those who test negative. Individuals who decline testing and self-report seropositivity receive the same content as those receiving positive test results. Specific topics addressed in Session II include:

- Provision of test results, if applicable;
- Meaning of test results;
- Review of prevention messages discussed in Session I;
- Discussion of medical followup and early treatment (for seropositive individuals);
- Partner notification (for seropositive persons to inform their drug and sex partners about potential risk of infection); and
- Distribution of literature and other materials to support risk reduction, including referrals.

Getting Started

Session II should be conducted in a private, individual setting. Materials required for Session II include:

- *Cards 19 through 24, and Cards 4, 6, 7, and 10 through 14;*
- Cup with clean rinse water;
- Container with full-strength household bleach;
- Empty cup;
- Bottle cap (cooker model);
- Demonstration syringe (no needle);
- Dildo or other anatomical model;
- Condom;
- Lubricant;
- Pair of blunt scissors;
- Written referrals for HIV, HBV, HCV and other STD testing, pre- and post-test counseling, and treatment; drug treatment and relapse prevention; sterile syringe access; and other social and medical services;
- One or more needle hygiene kits; and
- One or more condom kits.

HIV, HBV, and HCV Seronegative (and Unaware) Participants

Provision of Test Results

After welcoming the participant, the interventionist should begin the session by providing test results, as applicable. The interventionist may involve the participant in confirming the identifying information recorded on laboratory test result forms ("lab slips") to ensure that results for the correct individual are read. Next, the interventionist should show the test results to the participant and should state the test results verbally. Since individuals are likely to be most anxious about HIV results, it is preferable to present these results first. It is important to allow sufficient time for participants to react and to verbalize feelings.

Meaning of Test Results

Card 19 describes the meaning of negative HIV test results. It explains that, although HIV antibodies were not detected in the present test, the individual may, in fact, be infected with HIV. The interventionist should make sure that the participant understands this point, as well as the importance of being tested again in 6 months, if appropriate.

Card 20 describes the meaning of positive HIV test results and recommendations for slowing or preventing the onset of HIV symptoms. Even though the participant did not test positive for HIV, he or she should understand the implications of a positive test result. The interventionist should note that a person who is seropositive is at risk of taking in more virus unless he or she practices protective behaviors. Furthermore, people who carry HIV can infect others, even though they may not have the symptoms of AIDS. They should be counseled to inform their drug and sex partners about potential risk of infection and the importance of getting tested and counseled for HIV and other blood-borne infections. Possible transmission between sexual partners, between injection drug partners, and from mother to child should be discussed.

Card 21 describes the meaning of negative HBV or HCV test results. It explains that high levels of HBV or HCV were not found in the blood at the time of testing.

Card 22 describes the meaning of positive HBV or HCV test results. It explains that an infected person can transmit the virus to others.

Card 23 contains recommendations for minimizing liver damage. This should be reviewed briefly with the participant.

Review of Prevention Messages

At this point, the interventionist should review the prevention material presented in Session I, using a subset of cue cards that discuss:

- How someone gets infected and behaviors that put people at risk *(Cards 4 and 10)*;
- The importance of cleaning injection paraphernalia and cleaning instructions *(Cards 6 and 7)*;
- Why latex condoms should be used and an introduction to the female condom *(Cards 11 and 12)*;
- How to talk with a partner about safer sex *(Card 13)*; and
- The benefits of drug treatment *(Card 14)*.

Condom and bleach rehearsals will accompany discussions of certain cue cards (*Cards 7* and *11*). Guidelines outlined in Chapter 5 for demonstration and referral should be followed.

Materials To Support Risk Reduction

Before concluding the session, the interventionist should ask the participant if he or she has questions and should provide written materials containing information discussed in the cue cards, as well as other materials to support risk reduction. In addition to providing literature about HIV, HBV, and HCV transmission and risk reduction, literature on the female condom may also be distributed. Referral lists for local drug treatment and relapse prevention programs and for HIV, HBV, and HCV testing and pre- and post-test counseling services should be offered (if available). Written referrals to other social and medical services also may be provided, even if not specifically requested. These may include agency names, addresses, phone numbers, business hours, and the names of contact persons. In addition, one or more needle hygiene kits and condom kits (described in Chapter 5) may be offered, as appropriate.

HIV, HBV, or HCV Seropositive Participants

Provision of Test Results

After welcoming the participant, the interventionist should begin the session by providing test results, as applicable. The interventionist may involve the participant in confirming the identifying information recorded on laboratory test result forms ("lab slips") to ensure that results for the correct individual are read. Next, the interventionist should show the test results to the participant and should state the test results verbally. Since individuals are likely to be most anxious about HIV results, it is preferable to present these results first.

It is important to allow sufficient time for participants to react and to verbalize feelings. The interventionist should be prepared for a range of reactions, including dismay, confusion, and anger. It may be more difficult for seropositive participants to absorb the information provided and to become engaged in discussion.

In some cases, crisis intervention may be needed when a participant has been informed that he or she has tested positive for HIV, HBV, or HCV. A helpful response should include empathy, warmth, a positive regard for the person and his or her feelings, and an effort to facilitate a clear understanding of the situation and available options. During the session, the interventionist should strive to:

- Listen actively and with concern;
- Encourage open expression of feelings (unless the participant is out of control and potentially dangerous);

- Help the participant to understand the crisis;
- Help the participant to gradually accept reality;
- Encourage the participant to explore new ways of coping with problems;
- Link the participant to a support network;
- Reinforce newly learned coping methods; and
- Arrange for followup after the immediate crisis is resolved.

Meaning of Test Results

In discussing the meaning of test results, the interventionist will be faced with one of several possible combinations of results, and must be careful to review the appropriate cue cards (HIV–, *Card 19*; HIV+, *Card 20*; HBV– or HCV–, *Card 21*; HBV+ or HCV+, *Card 22*). For example, if the individual is HIV-negative, HBV-negative, and HCV-positive, *Cards 19, 21,* and *22* should be reviewed. General instructions for discussing each card follow.

Card 19 describes the meaning of negative HIV test results. It explains that, although HIV antibodies were not detected in the present test, the individual may, in fact, be infected with HIV. The interventionist should make sure that the participant understands this point, as well as the importance of being tested again in 6 months, if appropriate.

Card 20 describes the meaning of positive HIV test results. The interventionist should inform the participant that he or she is infected with HIV, even though symptoms of HIV and AIDS may not have appeared. In general, it is helpful to proceed slowly and sensitively when discussing test results, and it is important to tell participants that those with whom they have engaged in risk behaviors may also be infected. Participants should be counseled to inform their drug and sex partners, if possible, about potential risk of infection and the importance of getting tested and counseled for HIV and other blood-borne infections. They should be encouraged to seek medical treatment for HIV and to follow recommended practices with regard to obtaining and adhering to medications to slow or prevent the onset of HIV symptoms. They should also be advised to get off and stay off drugs, and to maintain overall health through proper nutrition, rest, and exercise. The participant should be strongly encouraged to protect himself or herself against additional exposure to the virus, to seek personal medical care, and to seek medical care for his or her children, if applicable. In addition, the interventionist should warn against donating blood.

If the participant is female, she should understand the possibility of transmitting infection from mother to child, as well as the uncertain meaning of the presence of maternal antibodies in children.

Card 21 describes the meaning of negative HBV or HCV test results. It explains that high levels of HBV or HCV were not found in the blood at the time of testing. If the participant suspects possible exposure to HCV, he or she should be retested in 4 to 6 months. There is a window of about 3 months before a test registers positive because of the slow development of antibodies after infection.

Card 22 describes the meaning of positive HBV and HCV test results and explains that participants who test positive may have infected those with whom they have engaged in risk behaviors. If the individual tested negative for HCV but suspects having been exposed, he or she should be retested in 4 to 6 months. There is a period of about 3 months before a test registers positive because of the slow development of antibodies after infection.

Risk Reduction Review

In addition to the information provided in *Cards 19 through 22*, the interventionist may attempt to review techniques for needle disinfection and condom use, if appropriate. This decision should be based on the participant's reaction to his or her positive results. Since positive participants may have a limited ability to concentrate on new information after learning their test results, it may be helpful to schedule a return visit, during which the interventionist may follow up on referrals made, review prevention information, and provide additional information and support, as needed.

Medical Followup and Early Treatment

Card 23 describes how individuals who test positive for HBV and/or HCV may slow or prevent the onset of serious liver disease.

Partner Notification

Card 24 presents issues concerning notification of individuals who may have been exposed to HIV, HBV, and/or HCV through sex or injection drug use with the participant. The interventionist should be familiar with local partner notification programs and should provide information about these available but optional services to the participant. The interventionist should also encourage individuals who learn that they are seropositive for HIV, HBV, or HCV to inform their drug and sex partners about their potential risk of infection, if possible, so that they too may seek testing and counseling and prevent transmission to others.

Materials To Support Risk Reduction

Before concluding the session, the interventionist should ask the participant if he or she has questions, and should provide written materials containing information discussed in the cue cards, as well as other materials to support risk reduction and behavior change. In addition to providing literature about the meaning of positive test results, the interventionist should provide:

- Referral lists of local medical treatment agencies, clinics, and physicians who treat HIV/AIDS, HBV, and HCV patients;
- Information about drug treatment and relapse prevention programs;
- Information about the availability of sterile syringes in the local community; and
- Information about HIV, HBV, and HCV prevention, testing, pre- and post-test counseling, and treatment services (if available).

Written referrals to other social and medical services also may be provided, even if not specifically requested. Referral lists may include agency names, addresses, phone numbers, business hours, and the names of contact persons. In addition, one or more needle hygiene kits and condom kits (described in Chapter 5) may be offered, as appropriate.

SECTION III:

Implementation Issues

Introduction to Impementation Issues

The NIDA Community-Based Outreach Model presented in this manual for reducing the spread of HIV/AIDS among drug users involves two interrelated components designed to facilitate behavior change among at-risk drug users: (1) community-based outreach and (2) two sessions of education and risk-reduction counseling that are organized around testing for HIV, HBV, and HCV to provide pre- and post-test counseling to help drug users learn their serostatus and the behavior changes needed to reduce transmission risks.

Implementing these components in a single program, so that participants are contacted repeatedly, is critical to serving the needs of at-risk populations in their natural environment in their neighborhoods and communities. This Section explains how to go about implementing the Community-Based Outreach Model and provides helpful information for managing a program designed to reach individuals at risk of contracting and/or transmitting HIV, HBV, and HCV.

- Chapter 7
- Chapter 8

CHAPTER

Logistical Concerns

Establishing a Field Station

Although it is not necessary for effective community-based outreach, establishing a community field station can provide a home-base for outreach workers and an environment for conducting the risk-reduction education sessions and testing and counseling activities described in the present Model. Additional social and medical services, such as support groups, medical care and referrals for care, food bank services, and information on available housing assistance, may also be provided by a field station. Operated as drop-in centers for drug users at risk of viral infection, field stations can increase program visibility and become an effective, recognized means of maintaining contact with program participants over time.

Depending on the community and its resources, the following sites may be considered for establishing a community field station:

- Storefronts;
- Mobile testing units;
- Temporary locations in motel or hotel rooms;
- Offices in health department facilities;
- Conventionally leased office spaces;
- Facilities provided by affiliated universities or research institutions;
- Offices in buildings where other community medical and social support services are located; and
- Multipurpose locations, such as a permanent administrative office combined with a mobile unit, a hotel, or other temporary location.

Hours of Operation

Opinions differ widely regarding the most appropriate hours of operation for community-based outreach activities. Programs differ with regard to times designated for contacting at-risk individuals in street and other community settings. Two guidelines are recommended for consideration: First, once hours of operation have been assigned, all workers should observe them, regardless of personal preferences. Second, when double shifts or late-night hours are required, administrative or supervisory staff should always be on call

when community-based outreach workers are in the field. This practice will ensure that someone is always available to answer questions, give referral advice, and provide support for community-based outreach workers. *When* community-based outreach takes place is just as important as *where* it is conducted.

Working in Teams

It is advantageous for community-based outreach workers to work in teams of two, matching former drug abusers with shorter recovery experience with staff members who have never abused drugs or who have been in recovery longer. The encouragement and maintenance of sobriety are important reasons for working in teams. Other reasons for pairing community-based outreach workers include improved continuity of the intervention should one member leave permanently or for an extended period of time; team members' ability to provide support for one another in encouraging particular individuals to change; and greater safety. If former drug users are hired, it is considered prudent to require a minimum 2-year period of abstinence. Having a support group to help maintain abstinence can also be helpful to staff members who are, themselves, in drug recovery.

Maintaining Contact With Participants

For community-based programs that offer multiple sessions or plan to maintain regular contact with participants, it is necessary to have a system for locating participants and reminding them of scheduled activities. For new program participants, the community-based outreach staff should complete a detailed locator form that includes information such as the participant's given name and street name(s), home address, a mailing address (if different from the home address), telephone number, alternate contact information (family and friends), and places in the community where the participant can be found regularly. To determine a participant's most reliable address, a staff member might ask, "If you were to win a lottery, where would you want the check mailed?"

Telephone calls may be made to remind participants about upcoming appointments and to notify participants of missed appointments. In addition, reminder letters for upcoming appointments can be mailed, as can additional letters reminding a participant of a missed appointment and encouraging him or her to reschedule the appointment as soon as possible. If telephone calls and letters fail to prompt re-engagement, and if program staff have not determined that the individual has moved, died, or been incarcerated, community-based outreach workers may visit the last known address, as well as other places where the participant is known to socialize, and try to re-engage the participant in program activities.

Recordkeeping and Accountability

A form documenting any contact of longer than 5 minutes with potential participants can be extremely useful and is recommended. The contact form should include all relevant details of each participant encounter, including the names of both the participant and the staff member, the date and time of the contact, as well as contact duration and location. The nature of the contact also should be documented, and space should be provided for recording notes.

Contact forms can be helpful for monitoring community-based outreach activities. Data from contact forms can be entered into a computerized database, from which a variety of special reports can be generated at regular intervals. For example, one CA outreach site generated a weekly report for community-based outreach workers, listing all locations where participants had been observed in the recent past. This information was especially useful for relocating participants.

Other forms of reporting may include the following:

- Documenting check-in and check-out times;
- Tracking the number of persons referred for Sessions I and II, as well as those receiving social service referrals;
- Maintaining a log of telephone contacts between community-based outreach workers and the administrative office or supervisor; and
- Performing occasional supervisory field visits and documenting observations.

CHAPTER

Training and Supervision

All newly hired community-based outreach staff members should receive preservice training, job-specific instruction, and supervised on-the-job training in outreach responsibilities. Outreach training typically includes two phases and involves formal instruction as well as role-playing. The first phase of training is usually conducted in an office or other controlled setting, and the second phase is conducted in the field.

Basic HIV/AIDS Education

During initial training, newly hired field staff should receive education in the basics of HIV/AIDS, HBV, and HCV. An in-depth understanding of virology and immunology is not necessary to conduct effective prevention activities; however, staff members do require basic knowledge about medical and epidemiological concepts related to HIV (as well as HBV and HCV) infection. These concepts include the following:

- Definitions of HIV, HBV, HCV, and other STDs, and how they are transmitted and prevented;
- Relative risks of behaviors associated with transmission;
- Other health consequences related to drug use;
- HIV, HBV, and HCV antibody testing procedures, and the meaning of seropositive and seronegative test results;
- Treatment options for HIV/AIDS, HBV, and HCV;
- The characteristics and natural environment of the target population;
- Current information on local seroprevalence rates and projections for the spread of HIV/AIDS, HBV, HCV, and other STDs; and
- Basic knowledge of HIV, HBV, HCV, and other STDs.

In addition, all community-based outreach workers should be counseled on HBV testing, and information about the importance, availability, and accessibility of HBV-related services, including vaccination and treatment, should be provided.

Job-Specific Training

After completion of basic HIV/AIDS training, community-based outreach workers should receive job-specific instruction, including the specific objectives of HIV prevention, education, and risk-reduction programs; strategies for conducting community-based outreach interventions; and, when appropriate, information about drug abuse treatment and relapse prevention programs. Community-based outreach workers must learn strategies for accessing target populations of drug users in their natural environments, as well as important paperwork and other documentation requirements.

Training should include such topics as crisis intervention, prevention case management, and the availability of community health and social service resources. Training activities may be both didactic and interactive, and role-playing sessions may be tailored to one-on-one, door-to-door, and group contexts. Videotaping and/or audiotaping of practice sessions also may be very instructive. In addition, training activities may include visiting local agencies to facilitate community networking and coalition-building.

Instruction on conducting street outreach should cover the following:

- How to identify and approach target group members;
- When and where to distribute prevention materials;
- How to explain the program's purpose and instill trust;
- How to verify locations where participants can be recontacted for further participation;
- How to handle requests for money;
- How to deal with offers of drugs or sex;
- How to handle potential street danger;
- How to deal with police officers; and
- How to handle basic safety and security issues that may arise.

Once proficiency is gained in the office-based training, field-based training can begin. Community-based outreach workers may work in pairs during the training period, and each pair should spend at least 2 weeks in designated outreach sites with a senior outreach staff person. Supervisors may consider accompanying outreach teams at least 1 day per week to monitor delivery of the intervention.

Community-based outreach workers in training are likely to learn best by having the opportunity to first observe, and later conduct, relevant intervention components. Events of the day can be discussed in a team meeting at the close of each day, and role-playing

activities can be conducted during these meetings to enhance communication skills. This introduction should allow staff members to develop styles of outreach that adhere to the NIDA Community-Based Outreach Model and that are also comfortable and acceptable.

Supervisors should be prepared to provide assistance and feedback to new outreach staff members. The outreach staff should be familiarized with a daily routine for conducting street outreach. They also should be provided with suggestions for improving the effectiveness of community-based outreach, for correcting possibly inaccurate information they may believe to be true, and for overcoming potential obstacles they may encounter. In addition, they should be assisted in developing a schedule for recording their outreach contacts, referrals, interventions, and other outreach activities each day, and in completing paperwork designed to facilitate monitoring. Table 4 lists suggestions that supervisors may wish to recommend.

TABLE 4 Suggestions for Community-Based Outreach Workers

Be sure to:

- Carry identification at all times;
- Let contacts know the limits of your job;
- Maintain confidentiality;
- Keep your supervisor or coworkers advised of your whereabouts;
- Consult your supervisor about any difficult situation;
- Offer any reasonable assistance that is requested;
- Work in pairs;
- Maintain relations with police as established in ground rules with the police chief;
- Be mindful of the media; and
- Maintain support for workers in drug recovery.

Avoid:

- Drinking or taking drugs on the job;
- Engaging in activities or behaving in a manner that could threaten your job security;
- Buying or receiving drugs;
- Buying or receiving property of any value from participants;
- Paying for sex or accepting sexual favors from participants;
- Asking about or listening to drug trafficking information (except to locate outreach areas);
- Socializing with persons who you know are carrying drugs;
- Receiving, carrying, or confiscating weapons;
- Giving money directly to participants; and
- Violating a participant's confidentiality.

Once community-based outreach workers possess basic knowledge about HIV/AIDS, are aware of their responsibilities, and understand safety issues, they are ready to work with at-risk individuals in field settings.

Counselor and Educator Training

Counselors and educators may be selected on the basis of prior experience as outreach workers, previous counseling experience, and/or demonstrated aptitude as HIV/AIDS educators. Like community-based outreach workers, counselors and educators may be former drug users. Organizations may wish to use only counselors and educators who are certified HIV/AIDS educators.

Counselors and educators share many personal characteristics with community-based outreach workers; however, using the same personnel for outreach activities and counseling/education sessions is strongly discouraged. Participants are likely to be uncomfortable encountering outreach workers in the field who once gave them their HIV antibody test results.

Ongoing Training

Initial on-the-job training should be limited to 4 weeks, and ongoing training should be scheduled regularly thereafter. Training events, conducted by senior staff, outside training teams, and outside experts, should cover a range of topics including advances in HIV/AIDS research, treatment innovations, techniques for stress management, and prevention of job burnout. These last two topics are particularly important, and program management should make sure they are covered individually (i.e., one-on-one counseling) and in groups (e.g., rap sessions). In addition, links to other outreach programs can provide a peer network and opportunities for further learning.

Supervision (Monitoring and Feedback)

Successful community-based outreach programs require competent supervision. The outreach supervisor should assist and support community-based outreach workers in maintaining the consistency of intervention activities. Community-based outreach teams spend much of their day unsupervised on the street. To maintain intervention consistency, outreach supervisors should spend time on the streets each week with each team.

In addition, the roles and responsibilities of outreach workers contain a certain amount of inherent ambiguity, which can be frustrating for outreach workers as well as for supervisors. To alleviate some of that frustration, supervisors should seek to instill a sense of order in the job. They play a central role in hiring new outreach staff and defining, from the outset, the parameters of the position. The following recommended procedures can help community-based outreach workers organize their daily responsibilities and provide structure for their work:

- Supervisors should meet with outreach staff at the beginning of each day to coordinate that day's activities;
- Near the end of each day, staff and supervisors should meet again to complete paperwork; and
- After the paperwork is given to supervisors, a team meeting should be held. These meetings typically center on events that occurred during the day, but they also afford an opportunity for the staff to receive feedback and provide information to each other and the supervisor. This information might include new locations to find participants and emerging trends in risk behaviors. These discussions are particularly important, since they can lead to needed modifications in the content or location of outreach efforts.

Creating a Supportive Environment

No professional set of qualifications for community-based outreach workers exists, and no formal body of knowledge for community-based outreach workers is available. This makes it all the more important to have the support of a multidisciplinary professional team. Program managers should provide direct support by being adaptable, open-minded, willing to take risks, and able to judge when risks are unacceptable. Not coincidentally, these are the same attributes required of a community-based outreach worker.

Support for the community-based outreach worker includes identifying training needs, ensuring safety at work, and providing adequate backup when needed. Safety is paramount and should always be viewed as taking precedence over other concerns. Clarification of what constitutes an unsafe situation may be necessary, and withdrawing from such a situation should be the first recourse, strongly supported by management. Key issues to clarify include points of contact, when and how to report to the program office, and appropriate means of communication.

Good management practice includes establishing a balance between clear lines of responsibility and an appropriate degree of autonomy for community-based outreach workers. Supervisors should be flexible enough to allow community-based outreach workers to experiment, but recognize the need for guidance when an approach must be modified or

abandoned. It is also important that managers, in addition to providing regular supervision, advocate the role of community-based outreach workers to local authorities, including the police.

Supervisors should be sensitive to the personal and occupational challenges facing community-based outreach workers. Supervisors should also be prepared to provide emotional support or counseling to address issues confronted in community-based outreach, such as death and dying, "tough love," interpersonal conflict, personal and professional boundaries, stress, negative feelings, career development, and relapse risk for former drug users serving as outreach workers.

In addition, supervisors are responsible for ensuring adherence to the protocols, the organizational policies and employment requirements, the safety of the staff, and the confidentiality of participants.

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7 " 'Backloading' is a term referring to one of several methods used to transfer drug solution between syringes. Backloading involves squirting the drug from a donor's syringe into the barrel of the recipient's syringe after the plunger is removed. A second method is for the donor to redeposit the drug from his or her syringe into a cooker, and for the recipient then to draw the drug up into his or her syringe. A third method, 'frontloading,' consists of squirting the drug into the hub of the recipient's syringe after the needle is removed (Jose et al., 1993; Koester and Hoffer, 1994; Koester at al., 1990); this method is used less frequently in the United States where disposable insulin syringes with nondetachable needles are customarily used." (Needle et al., 1998)

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61

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Appendix A

CARD

What Is HIV/AIDS?

- The human immunodeficiency virus (HIV) is the virus that causes AIDS, or acquired immunodeficiency syndrome.
- HIV is found in certain body fluids (blood, semen, vaginal fluid, breast milk) and can be passed from one person to another through contact with blood and other body fluids; for example, during injecting drug use and unprotected sexual contact.
- HIV/AIDS can destroy the body's ability to fight off infections and can lead to a group of medical conditions known as "opportunistic infections" and other serious diseases.
- Since AIDS was formally identified among IDUs in 1981, the disease has had a dramatic public health impact in the United States and around the world.
- More than 16 million people worldwide have died from AIDS since the epidemic began, and as of July 2000, an estimated 34 million people are living with HIV/AIDS.

CARD 2

What Is Hepatitis B?

- Hepatitis B virus (HBV) is found in the blood of persons who have this disease; it can cause serious liver damage, such as cirrhosis and liver failure.
- HBV is spread by contact with the blood or sexual fluids of an infected person; however, hepatitis B is a vaccine-preventable disease.
- Clinical symptoms of hepatitis B may include fatigue and other flu-like symptoms, and jaundice (yellowing) of the skin and eyes. Close to 95 percent of those who get HBV can completely recover because the body can fight it by developing antibodies to it.

CARD 3

What Is Hepatitis C?

- Hepatitis C is a liver disease caused by the hepatitis C virus (HCV), which is found in the blood of persons who have this disease. The infection is spread primarily through contact with the blood of an infected person.
- HCV may be shed in genital secretions and saliva as well as in blood.
- HCV is serious for some persons, but not for others. Most people who get HCV carry the virus for the rest of their lives. Most of these persons have some liver damage but may not feel sick from the disease for many years.
- People with liver damage caused by HCV may develop cirrhosis (scarring) of the liver, liver cancer, or liver failure that may take many years to develop.
- Some clinical symptoms of HCV are jaundice, fatigue, abdominal pain, loss of appetite, nausea that comes and goes, and vomiting.
- However, not everyone who becomes infected gets the symptoms.

CARD 4 Facts About HIV, HBV, and HCV Transmission

- HIV (the AIDS virus), hepatitis B virus (HBV), and hepatitis C virus (HCV) are present in semen, blood, vaginal fluid, and breast milk.
- HIV, HBV, and HCV are transmitted:
  - — by directly or indirectly sharing needles and other drug injection equipment including cookers, cottons, and rinse water;
  - — by sharing drugs taken from the same syringe through frontloading or backloading or some other way;
  - — by having unprotected sex, especially with someone who injects drugs or who has several sex partners;
  - — by receiving blood from an infected person; and
  - — from mother to child during pregnancy or the birth process. They are possibly also transmitted by breastfeeding.
- Abusing alcohol or other drugs can be risky because:
  - — they may weaken your immune system, making it easier to get HIV/AIDS and other infections; and
  - — they may influence your perceptions about personal risk and make you less cautious about using other drugs and engaging in unprotected sex.

CARD 5

Facts About HIV/AIDS, HBV, and HCV That Are Often Misunderstood

- You can't get HIV, HBV, or HCV from sneezing, hugging, or coughing, or from food or water; from sharing eating utensils or drinking glasses; or from casual contact.
  However, do not share toothbrushes, razors, or other personal care articles that might have blood on them.
- You can't get HIV, HBV, or HCV from a dry kiss.
- You can't get HIV, HBV, or HCV from clothes, a telephone, or a toilet seat.
- You can't get HIV, HBV, or HCV from a mosquito bite or other insect bites.

CARD 6 Reducing Your Risk of Infection

- If you inject drugs, you can get infected with HIV, HBV, or HCV by sharing needles, syringes, and other injection equipment that someone else has used.
- You can also get HIV, HBV, and HCV by sharing cookers, cottons, or rinse water.
- Merely rinsing used works in water, even hot water, will not kill HIV, HBV, or HCV. You must use bleach.
- To reduce your risk of infection:
  - — Best method: stop using and injecting drugs.
  - — If you can't stop injecting drugs, never reuse or share needles. Use only a new, sterile needle or a needle that only you have used before.
  - — If you do share needles, disinfect the needle every time before you inject drugs. Disinfecting used syringes with bleach can reduce the risk of transmission, but a disinfected syringe is not as safe as a new, sterile needle and syringe.
- Do not put your needle in someone else's syringe rinse water, cotton, or cooker. HIV, HBV, or HCV can live in blood in all these places.
- Do not share drugs that have been drawn up in a syringe someone else has used.

CARD 7

Cleaning Injection Paraphernalia: Bleach, Bleach, Water, Water

- Rinse syringe with clean water.
- Always clean with full-strength bleach.
- Keep bleach in syringe and thoroughly shake up the bleach for 30 seconds to reach all areas of the syringe.
- Discard the waste into a sink, toilet, or sewer whenever possible.
- Perform the bleach process again.
- Whenever possible, rinse with clean water and discard the water into a sink, toilet, or sewer.
- Rinse again.
- After you finish with bleach, bleach, water, water, remove the plunger from the syringe and clean both parts again with bleach and water.
- Never share any of your equipment (cooker, cotton, or rinse water).
- Clean your cooker with full-strength bleach and rinse with clean water.

If bleach is not available:

- Thoroughly rinse with water several times to reach all parts of the syringe or equipment.
- Boiling needles and syringes for 15 minutes between uses can sterilize the equipment. However, boiling may change the shape and function of the plastic syringes widely used by drug injectors in the United States.

CARD 8

Reuse of Injection Equipment

- Direct needle sharing occurs when you use another person's syringe after he or she has used it.
- Indirect sharing occurs when fluids are mixed without actually passing a syringe from one person to another.
- Routes of indirect sharing include:
  - — Putting syringes in the same container of water or drug solution;
  - — Using a plunger from a previously used syringe to mix the drug solution;
  - — Using a used syringe to distribute or return the drug;
  - — Drawing drug from a shared cotton filter;
  - — Returning the drug to a shared cooker;
  - — "Beating the cotton" and "scraping the cooker"; and
  - — Rinsing a syringe in other people's water.

CARD 9

Benefits of Needle Exchange

Provides a means for:

- Exchange of potentially contaminated syringes for sterile syringes,
- Distribution of bleach,
- Referrals for drug treatment,
- Distribution of condoms,
- Testing and counseling for HIV/AIDS,
- Screening for TB, and
- Screening for STDs.

CARD 10 Facts About Cocaine and Crack

- Sometimes people smoke crack or snort cocaine rather than inject it. But that doesn't mean they are safe. Even if they only smoke or snort, moderate and heavy cocaine users are still increasing their risk of contracting HIV, HBV, HCV, or other STDs. Here's why:
  - — People often have more sex when they use cocaine, and they often forget to wear latex condoms or to ask their partner to wear a condom.
  - — Some people sell sex to get cocaine or to get money for cocaine. This may mean they have more sex or unprotected sex.
  - — Crack and cocaine may weaken the immune system, making it easier to get HIV, HBV, HCV, and other STDs.
  - — Crack and cocaine often make it difficult to reach sexual climax. This may lead to prolonged intercourse and increased chances for getting cuts and abrasions, which could result in blood-to-blood contact and the transmission of HIV, HBV, HCV, and other STDs.
- If you are a crack or cocaine user, you can decrease your chances of getting HIV, HBV, HCV, or other STDs by getting off drugs.
- If you can't get off drugs, be sure to wear latex condoms or make sure your partners do.

CARD 11

What You Need To Know About Male Condoms

- Condoms that are kept on all the way through sex help prevent the spread of sexually transmitted viruses including HIV, HBV, HCV, and other STDs.
- Condoms made of lambskin, sheepskin, and other natural materials do not protect you from getting HIV, HBV, HCV, and other STDs. You must use latex condoms.
- Use only water-based lubricants with condoms.
- Sexually transmitted diseases often cause genital lesions or sores. When these occur, it's easier to get infected with HIV, HBV, or HCV. Male condoms can reduce the risks that lesions and sores present.
- Besides not having sex, the best way to protect yourself against AIDS, hepatitis B, and hepatitis C is by always using latex condoms.
- For receiving oral sex, men should use nonlubricated latex condoms, and women should use dental dams or a barrier such as plastic wrap without air holes (the type not for use in a microwave oven).
- To reduce your risk of getting HIV/AIDS, HBV, or HCV:
  - — Best method: do not have sex.
  - — Next best method: do not have sex involving penetration.
  - — Next best method: use condoms during all sex involving penetration.
- Spermicides, such as diaphragm jelly and contraceptive sponges, do not kill HIV, HBV, or HCV, so they should not be used instead of condoms.

CARD 12 What You Need To Know About Female Condoms

- Female condoms reduce the risk of acquiring sexually transmitted diseases and of becoming pregnant.
- Female condoms are polyurethane, bag-like devices that are placed in the female genital canal to protect it from seminal fluid and blood.
- Female and male condoms should never be used at the same time.
- Each female condom can be used only once. It must be thrown away after each sex act.

CARD 13

How To Talk With Your Partner About Safer Sex

- Learn as much as you can about HIV, HBV, HCV, and other STDs. That will make it easier to talk about safer sex.
- Decide when you want to talk. The best time is not just before having sex or when you are high.
- Decide in your own mind what you will and won't do during sex.
- Give your partner time to think about what you're saying. Don't rush.
- Pay attention to how your partner understands what you're saying. Slow down if you need to.
- Talk about the times that make it hard to have safer sex. These may be times when you don't have condoms or have used alcohol or drugs. Try to decide what to do at those times so you can both reduce the risk of contracting HIV, HBV, and HCV.
- If your partner does not want to practice safer sex, ask yourself if this is the type of person you really want to have sex with. When drugs and alcohol are used, be more attentive to prevention behaviors such as using condoms.
- If your partner gets angry or threatens you when you raise the issue of condoms, seek help from a violence prevention program.

CARD 14 Benefits of Drug Treatment

Drug treatment is beneficial because it can:

- Help you get off drugs and teach you ways to stay off drugs;
- Change your life, improve your health, and reduce your risk of contracting HIV, HBV, or HCV;
- Include counseling and support for you and family members who may also need help;
- Include referrals for other health and social services;
- Include support for dealing wth HIV/AIDS and other problems; and
- Help turn your life around by giving you hope and the confidence to address your problem rather than giving up.

Even if you can't get into treatment now, you can be given information on support groups that can help you until a treatment program can be found for you. You may also be referred to local syringe exchange programs to minimize risks of acquiring and transmitting infections from dirty or reused syringes.

CARD 15

The HIV Test

- The HIV test (blood test) screens for the presence of antibodies that have developed in response to the HIV virus.
- A positive test result means that you are infected with HIV and can give it to others.
- A negative test result may mean that you are free of the virus. There is a period of time between infection and when the test shows that you are infected. This is called the "window period." During this time, you can test negative for HIV, but you may actually have the virus. The average window period is 3 weeks. It's a good idea to be tested again in 6 months to be sure you don't have the virus. (Between tests, if you have sex, make sure you use latex condoms. If you use needles, make sure you don't share works—use clean works.)
- We recommend you take the test and learn your test results because:
  - — Treatment is available for HIV infection; and
  - — You can plan a course of action that is best for you, your family and friends, and your community.
- Some people are anxious about taking the HIV test or getting test results. Our staff is prepared to discuss any concern you may have about getting tested. Please feel free to ask questions, so you can feel better about getting the test.

CARD 16 The HBV and Liver Function Tests

- The initial HBV test screens for antibodies to HBV and will tell you if you have ever been infected.
- If you test positive, a second test will be performed to determine if you are currently infected and can transmit the virus to others.
  - — If the second test is positive, additional liver function testing may be performed.
- If the initial test is negative, you will need another test to see if you have been successfully immunized.
  - — If this test is negative, you are eligible for HBV vaccination.
- In general, public health officials recommend HBV testing as important and beneficial.

CARD 17 The HCV Test

- The test screens for the presence of antibodies that have developed in your bloodstream in response to HCV.
- For people who test positive for HCV antibodies, supplemental tests may confirm the presence of the virus, may measure their viral load, and may include genotyping.
- The tests do not distinguish between acute, chronic, and resolved infection.
- There is no immunization for HCV, but some people can be treated.

CARD 18

What To Do if You Are Infected With HIV, HBV, or HCV

- It is important to get early medical treatment.
- Be safe. There are other viruses that can make you sicker. Do everything you can to reduce your risk.
- HBV or HCV carriers may be infected throughout their lives. You have a greater chance of developing liver cancer or cirrhosis of the liver if you have chronic infection with HBV or HCV.
- There is no treatment for hepatitis viral infections. People who have not been infected with HBV can be immunized.
- Some things you can do to maintain your health and fight disease:
  - — Stop or at least reduce drug use;
  - — Reduce or stop alcohol consumption;
  - — Eat healthy foods;
  - — Get proper rest;
  - — Get proper exercise;
  - — Think positively—consider joining a support group; and
  - — Get regular preventive medical care.

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II

Appendix B

CARD 19

Meaning of Seronegative HIV Test Results

- Negative HIV test results mean that HIV antibodies have not been found in the blood.
- Individuals who test negative may be infected with HIV. This can happen if your body hasn't yet produced enough antibodies to be detected.
- It usually takes 2 weeks to 6 months after you are infected for your body to produce a detectable level of antibodies.
- Anyone who has engaged in risk behaviors in the last 6 months should be retested for HIV in the next 6 months. (Between testing, if you have sex, make sure you use latex condoms. If you use needles, make sure you don't share works—use clean works.)
- Anyone who has engaged in risky behaviors since 1977 should not donate or sell blood.

CARD 20 Meaning of Seropositive HIV Test Results

- A person who tests positive for HIV is infected with the virus and can infect others.
- A person who tests positive for HIV may not have symptoms of AIDS. These symptoms may not develop for 5 to 10 years.
- The sexual partners, shooting buddies, or children of people who test positive may also be infected.
- A seropositive person should not donate or sell blood.
- A seropositive person should seek and receive regular medical care.
- A seropositive woman risks passing the virus to her fetus if she is pregnant and to her child if she is breastfeeding. Therapies and infant formula are now available and usually recommended.
- Early medical treatment may prevent passing the virus from mother to fetus.
- A seropositive person should never exchange body fluids during sex (vaginal, oral, or anal): Always use a latex male condom or a female condom.

CARD 21

Meaning of Negative HBV or HCV Results

- Negative test results mean that antibodies to the hepatitis virus were not found in the blood.
- A negative test does not mean that a person is free of the virus. Since the test screens for virus levels that are present for a short period, a person can be infected and still test negative.
- Anyone who continues to engage in risky behaviors should be retested in 6 months.
- Anyone who is at high risk for HBV or HCV infection should consult a health care professional for additional testing, possible monitoring, and immunization for HBV.

CARD 22

Meaning of Positive HBV or HCV Test Results

- Positive HBV or HCV test results mean you have antibodies to the virus.
  - — Almost all drug users who have antibodies to the virus actually have the virus.
  - — This test does not tell you if the virus has already damaged your liver or if it is damaging it right now.
  - — You must get more tests to find out how much damage has been done and if you need treatment for it at this time.
- A positive test result indicates infection and the ability to transmit it to others through blood and possibly through saliva, mucus, sweat, tears, and urine. HBV (and possibly HCV) can be transmitted through semen and vaginal fluids.
- A person who tests positive may not have hepatitis symptoms such as jaundice (yellowing) of the skin and eyes, fatigue, and other flu-like symptoms.
- A person who tests positive should not donate or sell blood or donate an organ.
- A woman who tests positive risks passing the virus to her child if she is pregnant.
- Sexual partners, shooting buddies, and the children of those who test positive may be infected. They should be tested and become immunized against HBV if they are not infected. There is no immunization available for HCV.
- A person who tests positive should get regular preventive medical care, including more testing and liver monitoring.

CARD 23

How To Slow or Prevent Onset of Serious Liver Disease

- See a doctor for additional tests to find out if you need treatment now.
  - — A doctor will take more blood from you and test it to see if HBV or HCV is damaging your liver.
  - — A doctor may also perform other tests to see how much damage has already been done to you.
- Do not drink alcohol.
  - — A little more than 1 out of 10 people (12%) who don't drink will develop cirrhosis within 20 years of infection.
  - — Almost 6 out of 10 heavy drinkers (58%) develop cirrhosis within 20 years of infection.

CARD 24

Risk-Reduction Counseling and Partner Notification

- HIV pre-/post-test education and risk-reduction counseling...
  - — offers opportunities to drug users to learn their serostatus for HIV, HBV, and HCV;
  - — helps them to assess and understand their personal risk;
  - — provides new information and skills to reduce infection risks and prevent transmission to others; and
  - — enables seropositive persons to inform their drug and sex partners about potential risk of infection and the importance of getting tested and counseled for HIV and other blood-borne infections.
- Seropositive persons may prefer, and can request, assistance from outreach workers in contacting and informing their drug and sex partners about potential risk of infection, and many health departments can help locate and counsel partners.
- State laws vary on mandated partner notification, and partners are generally not notified without your permission.

Appendix C

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APPENDIX C

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APPENDIX D

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98

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